Republic of South Sudan

Country Operational Plan (COP) 2016

Strategic Direction Summary

June 10, 2016

Table of Contents

Goal Statement

The overarching goal of the PEPFAR program in the Republic of South Sudan (RSS) is to, in collaboration with the Global Fund for AIDS, Tuberculosis and Malaria (GFATM or Global Fund), help the country build its HIV program so that quality services are available and accessible to all. By targeting high HIV prevalence areas, PEPFAR will assist RSS to move toward epidemic control, with 15,927 new HIV patients on antiretroviral therapy (ART) and 29,712 total on ART by the end of FY2017. These ambitious targets can only be achieved by rolling out implementation of Test and START and new service delivery models, including multi-month scripting (MMS).

In COP16, PEPFAR will focus on five counties where 25% of all people living with HIV (PLHIV) reside. By focusing resources in these Aggressive Scale-up sub-national units (SNUs), 75% of PLHIV in these SNUs will know their status, 73% of those who know their status will be on treatment, and 70% of those on treatment will be virally suppressed by the end of FY2017. This represents significant progress in a country where only 8% of all PLHIV nationwide were on treatment in FY2015. Now that the Transitional Government of National Unity (TGoNU) has formed, and in anticipation of subsiding conflict , RSS can continue these substantial gains, achieving epidemic control in the Aggressive Scale-up SNUs by FY2019. This will require identifying 17,563new PLHIV and putting 21,848 new PLHIV on treatment.

In COP16, PEPFAR will also continue to support 11 Sustained SNUs. These counties, also located within the three Equatoria states, which comprise the highest prevalence areas of the country, are where an additional 19% of all PLHIV live.

To achieve these goals, PEPFAR will transition 4,006 people currently in pre-ART onto ART as Test and START begins. The program will also decentralize ART services, introducing ART at 13 existing PMTCT sites, for a total of 24 ART sites. Multi-month scripting (MMS) (from three to six months), including community distribution models where feasible, will be initiated in order to reduce the frequency of clinic and refill visits, and technical assistance for supply chain management and quantification will help ensure that ART sites maintain an adequate supply of drugs to support Test and START and MMS. In addition, by the beginning of FY2017, viral load (VL) testing will begin at the National Public Health Laboratory. COP16 activities will focus on establishing systems to ensure VL testing for all HIV patients in Juba.

PEPFAR will also make a number of changes to maximize program efficiency. Based on expenditure analysis data, it was determined that continued technical assistance in centrally supported SNUs was not cost efficient; thus, all support outside of the three Equatoria states will be shifted to the Global Fund- with the exception of three high burden centrally supported sites that will continue to receive technical assistance. In addition, to ensure improved linkage and retention, all service delivery implementing partners will support the continuum of care—including HIV testing and counseling (HTC), prevention of mother-to-child transmission (PMTCT), and ART (where applicable)—rather than having multiple partners supporting

different program areas within the same sites. Finally, programs will employ strategies such as index testing to better target HTC and achieve higher yields.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country profile

The Republic of South Sudan (RSS) became an independent nation on July 9, 2011, after experiencing decades of civil war. However, it again descended into crisis in December 2013, adversely affecting the health system and access to health services. An Agreement on Resolution of Conflict in South Sudan (ARCISS) was signed in August 2015, under which a TGoNU is expected to be formed; though the process has been delayed, the TGoNU was formed in April 2016, and there are hopes that this will lead to a decrease in conflict throughout the country.

The 2015 population projections are based on the pre-independence Sudan National Census of 2008, which estimates the current total population of the Republic of South Sudan to be 11,878,208. The ongoing civil war has resulted in internal displacement of about 1,700,000 people, with another 640,000 seeking refuge in neighboring countries. The gross national income of RSS was $13.3 billion in 2014, and the country's growth domestic income (GNI) per capita was about $1,100. The national Human Development Index (HDI) value for 2014 is 0.467, putting the country in the low human development category at 169 out of 188 countries (Human Development Report 2015, UNDP). Outside the oil sector, livelihoods are concentrated in low productive, unpaid agriculture and pastoralists work, accounting for around 15% of GDP. In fact, 85% of the working population is engaged in non-wage work, chiefly in agriculture (78%).

RSS has a generalized HIV epidemic with an adult prevalence of 2.7%. The epidemic is geographically concentrated in the southern states, with a prevalence of 6.8% in Western Equatoria, 2.6% in Central Equatoria, and 3.4% in Eastern Equatoria.[1] Based on 2014 Spectrum estimates, there are 193,376 PLHIV in RSS; only about 14% (Draft South Sudan Global AIDS Response and Progress Report, 2015) of these know their status. The estimates for PLHIV distribution by counties is illustrated in Map 1 below.

RSS has a national strategic plan for HIV/AIDS known as the "National Strategic Plan (NSP) for HIV and AIDS 2013-2017," which succeeds the National Strategic Framework 2008-2012. The NSP was prepared to guide the multi-sectoral national response to the HIV epidemic for five years, and details outcomes, outputs, indicators and priority interventions. The NSP is aligned to the national and international frameworks, including the Sustainable Development Goals (SDGs) and specifically SDG 3. SDG 3 includes a specific target (By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases

---

[1] Southern Sudan Antenatal Care Clinics Sentinel Surveillance Report, MOH, 2012

and other communicable diseases) that aligns with multiple RSS NSP targets and goals, and is also consistent with the ten UNAIDS 2011 High Level Meeting targets.

Map 1: South Sudan 2015 PLHIV estimates by county
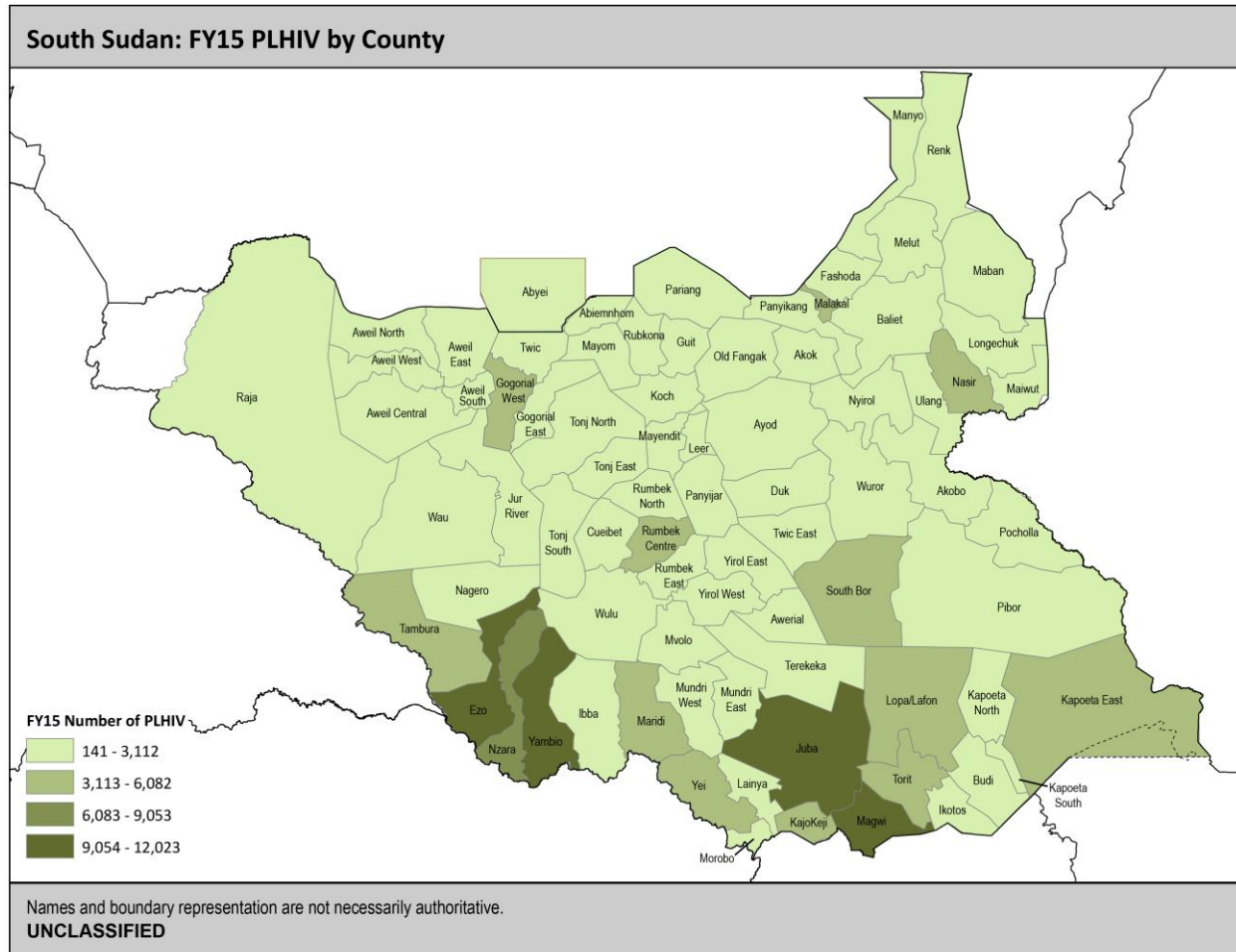
Current programmatic coverage is among the lowest in the world. Care and treatment scale-up remains significantly hampered by the limited number of ART sites and limited infrastructure to allow patients to travel to sites outside their immediate area. South Sudan currently has only 22 ART sites, three of which were destroyed by the recent conflict. The number of people on ART increased from 9,373 in 2014 to 15,715 by the end of 2015, and the number of newly initiated patients on ART rose from 4,588 in 2014 to 7,222 in 2015; however, this still represents only 8% coverage of all PLHIV. The number of children on ART increased from 437 in 2014 to 670 by the end of 2015, which is only 3.5% of all estimated children living with HIV.

In 2015, a total of 79,282 HIV tests were conducted, with 6,544 HIV positives identified, representing an 8.3% yield. There are 12,828 pregnant women in RSS estimated to have HIV, of which only about 13% know their status. The PMTCT yield was 5.4% for the 31,322 pregnant women tested for HIV in 2015. There were 1,447 pregnant women provided ARV prophylaxis,

which is 11% coverage; up to 97% of them received Option B+, a remarkable increase from only 40% in 2014 for the 776 pregnant women that were provided ARVs. Low ANC attendance at 53%[2] remains a limiting factor for access to PMTCT services.

PEPFAR's contribution to South Sudan's treatment program since 2013 has leveraged Global Fund commodities and human resource support to improve the national HIV delivery system, as evidenced by the increase in the number of people on ART since 2013. The program has achieved success through a combination of targeted service delivery approaches in HTC, PMTCT, and ART, combined with site support supervision and mentoring. Of note, while approximately 5,000 patients were actively receiving ART through December 2012, the number of patients active on ART nearly doubled in the two years after the initiation of targeted ART commodity and service delivery support under the PEPFAR "Treatment Bridge." With PEPFAR support, the number of patients on ART reached 9,373 in 2014, even despite the renewal of hostilities in December 2013.

South Sudan's current treatment guidelines are based on a CD4 count cut off of 500 cells per cubic millimeter. PEPFAR, Global Fund, and WHO have already initiated discussions to support the MOH in implementing a Test and START policy. It is expected that operationalization of Test and START will begin before the end of FY 2016.

---

[2] MOH Health Management and Information System Report 2015

Table 1.1.1 Key National Demographic and Epidemiological Data for South Sudan

Table 1.1.1 Key National Demographic and Epidemiological Data										Source, Year
	Total		**<15**				**15+**			
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	11,878,208	100	2,685,307	22.6	2,897,451	24.4	3,028,112	25.5	3,267,339	27.5	2015 Projection, based on 2008 Sudan census
HIV Prevalence (%)		1.6%		0.4%		0.3%		3.4%		2.2%	MOH 2014 HIV/AIDS Spectrum estimates
AIDS Deaths (per year)	12,740		1,059		852		5,999		4,830		MOH 2014 HIV/AIDS Spectrum estimates
# PLHIV	193,376		11,409		7,928		102,683		71,356		MOH 2014 HIV/AIDS Spectrum estimates
Incidence Rate (Yr)		NA		NA		NA		NA		NA	
New Infections (Yr)	18,224										MOH 2014 HIV/AIDS Spectrum estimates
Annual births	475,128	4.0									2015 Projection, based on 2008 Sudan Census
% of Pregnant Women with at least one ANC visit	251,750	53.0	NA	NA			NA	NA			MOH 2014 HMIS Report
Pregnant women needing ARVs	8,390	1.8†									MOH 2014 HIV/AIDS Spectrum estimates
Orphans (maternal, paternal, double)	110,000		NA		NA		NA		NA		Spectrum 2014 Estimates

											Source
Notified TB cases (Yr)	8,730		NA		NA		NA		NA		MOH 2014 HMIS Report
% of TB cases that are HIV infected	1,108	12.7	NA	NA	NA	NA	NA	NA	NA	NA	MOH South Sudan TB Data 2014
% of Males Circumcised	NA	NA			NA	NA			NA	NA	
Estimated Population Size of Men Who Have Sex with Men (MSM)*	NA	NA									
MSM HIV Prevalence	NA	NA									
Estimated Population Size of Female Sex Workers (FSW)	5,642	NA									FSW Juba and Yambio, SSAC 2012
FSW HIV Prevalence	25%	NA									2015 FSW BBS protocol Estimate
Estimated Population Size of People Who Inject Drugs (PWID)	NA	NA									
PWID HIV Prevalence	NA	NA									
Estimated Size of Priority Populations (military)	250,000	NA	NA	NA	NA	NA	NA	NA	NA	NA	2012 SPLA Bio-Behavioral Surveillance Study
Estimated Size of Priority Populations Prevalence (military)	NA	5.0	NA	NA	NA	NA	NA	NA	NA	NA	2012 SPLA Bio-Behavioral Surveillance Study

*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.

† Does not include diagnosed HIV+ patients already receiving treatment (ART)

	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART[4] (#)	Retained on ART 12 Months[5] (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Table 1.1.2 FY15 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART[3]		
Total population	11,878,208	1.6	193,376	15,715	11,943	NA	79,282	6,544	7,222[†]
Population less than 15 years	5,582,758	0.3	19,337	670	509	NA	4,293	441	378
Pregnant Women	475,128	2.7	12,828	1,447	NA	NA	31,322	1,694	1,447
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	5,300[6]	25.0	1,325	83[7]	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (Military)	250,000	5.0	12,500	605	NA	NA	2,736	281	195

[†] This number is greater than the number diagnosed as positive (column to the left), because it includes patients already on HIV care that were moved to treatment as well as those newly diagnosed and placed on HIV treatment (ART). In 2015, South Sudan moved from CD4 350 to CD4 500 for ART eligibility criteria which increased enrollment of those previously on care to ART.

1.2 Investment Profile

Government of South Sudan (GoSS) funding for health programs remains uncertain. The GoSS budgets approximately 4% of its annual budget to health, but the actual expenditures since the beginning of the conflict in December 2013 are not known. Previously, GoSS allocated a small budget to HIV annually, and these funds were primarily spent on staff salaries. The ongoing humanitarian crisis, conflict, and the drop in oil prices have caused a severe fiscal crisis in South Sudan. To this end, PEPFAR does not anticipate any new funding from the GoSS for HIV programs in the near future.

In June 2015, the Global Fund New Funding Model HIV concept note was approved for approximately $40 million, covering a period of two years and three months, i.e. October 1, 2015, to December 31, 2017. These resources are estimated to cover at least 25% of the population in

---

[3] APR15 data

[4] APR15 data, except where otherwise specified

[5] Based on average 76% retention rate, WHO Cohort Analysis Report, 2015

[6] FSW population size estimate is from peer validated mapping and size estimation data

[7] FY16 Q1 data

need of ART and PMTCT during this time period. PEPFAR will coordinate closely with the Global Fund to ensure complementarity and coordination of support. Under COP16, commodities, including ARVs and rapid test kits, have been budgeted to fill the gap based on estimations of total HIV testing and treatment numbers in country, in conjunction with expected Global Fund contributions to commodity procurement.

It is expected that the national response will continue to be heavily reliant on PEPFAR, which currently supports approximately 50% of services in the country, for both technical assistance and resources.

There are no other significant development partners supporting core HIV programs in South Sudan.

Table 1.2.1 Investment Profile by Program Area

Table 1.2.1 Investment Profile by Program Area[8] (NASA 2012)							
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% GoSS**	**% Bilateral**	**% UN Agencies**	**% Other International**	**% MDTF[9]**
Clinical care, treatment and support	$3,855,000	10%	90%	0	0	0	0	0
Community-based care	0	0	0	0	0	0	0	0
PMTCT	$8,170,750	59%	9%	0	2%	1%	1%	29%
HTC	$8,170,750	59%	9%	0	2%	1%	1%	29%
VMMC	0	0	0	0	0	0	0	0
Priority population prevention	$9,409,500	44%	6%	0	1%	26%	0%	21%
Key population prevention	0	0	0	0	0	0	0	0
OVC	$2,080,000	0	0	100%	0	0	0	0
Laboratory	0	0	0	0	0	0	0	0
SI, Surveys and Surveillance	0	0	0	0	0	0	0	0
HSS	$860,000	31%	57%	1%	2%	3%	1%	5%
Total	**$32,546,000**	**45%**	**18%**	**6%**	**1%**	**8%**	**1%**	**21%**

Note: these are data reported in COP15; current data are unavailable for GF and other funding sources; we will update this table when data are available

---

[8] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD
[9] MDTF funding through the World Bank funding concluded in 2013 and there will be no new funds for HIV

Table 1.2.2 Procurement Profile for Key Commodities[10]

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOSS	% Other
ARVs	$4,492,603	23%	77%	0	0
Rapid test kits	$238,500	100%	No data	0	0
Other drugs	$233.860	100%	0%	0	0
Lab reagents	$1,249,410	64%	36%	0	0
Condoms	No data	0	0	0	0
VMMC kits	$0	0	0	0	0
Other commodities	$50,000	100%	0	0	0
Total	**$6,264,373**	**38%**	**62%**	**0**	**0**

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total FY16 USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$15,000,000	$0	0	N/A	While there are no co-funded IMs, USAID funding provides substantial support for primary health care services in all PEPFAR-supported counties, allowing for synergies with PEPFAR programs.
USAID TB	$1,500,000	$0	0	N/A	
USAID Malaria	$6,000,000	$0	0	N/A	
USAID Family Planning	$6,000,000	$0	0	N/A	
Total	**$28,500,000**	**$0**	**0**	**N/A**	

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
CDC Central Initiatives	$0	$436,000	$0	0	N/A	To support EID and VL implementation and HIV rapid test quality assurance
Total	**$0**	**$436,000**	**$0**	**0**	**N/A**	

---

[10] FY17 estimates

1.3 National Sustainability Profile

RSS experienced decades of civil war, culminating in its recognition as an independent nation in July 2011. In December 2013, war broke out again, which led to destabilization of the fragile economy and health sector. In August 2015, an Agreement on Resolution of Conflict in South Sudan (ARCISS) was signed, under which a Transitional Government of National Unity was recently formed.

As the world's newest country, RSS has few of the critical elements in place to support a robust and transparent economy or government. The RSS HIV response remains almost entirely reliant on external donors like PEPFAR and the Global Fund. No areas of the HIV response in RSS are adequately covered in terms of finance, oversight, monitoring, or service delivery. The GoSS prioritizes security infrastructure over health, education, and other sectors.

[REDACTED]

1.4 Alignment of PEPFAR investments geographically to disease burden

In 2015, PEPFAR investments were closely aligned geographically to the disease burden. Excluding above national and national expenditures, a total of 84% of expenditures were in the three Equatoria states, the three highest prevalence states where 44% of all PLHIV live. The highest PEPFAR investment per PLHIV was in Central Equatoria. This is reflective of an overall high concentration of PEPFAR-supported sites in Juba and other counties of Central Equatoria; a total of 22% of all expenditures for FY15 were spent in Central Equatoria. Furthermore all partners have Juba-based head offices. Support to the central medical stores and other technical assistance (TA) count heavily under Central Equatoria where the capital is located. The second highest PEPFAR investment per PLHIV was in Northern Bahr El-Ghazal. This represents a relatively small total investment (less than 1% of total expenditures); however, because of the small total number of PLHIV (1.2% of all PLHIV) in this state, the expenditure per PLHIV remains high. Western and Eastern Equatoria states also show a high investment per PLHIV; these states represent 22% and 16% of the total PLHIV burden, respectively. (Figure 1.4.1)

Figure 1.4.1: 2015 South Sudan PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU
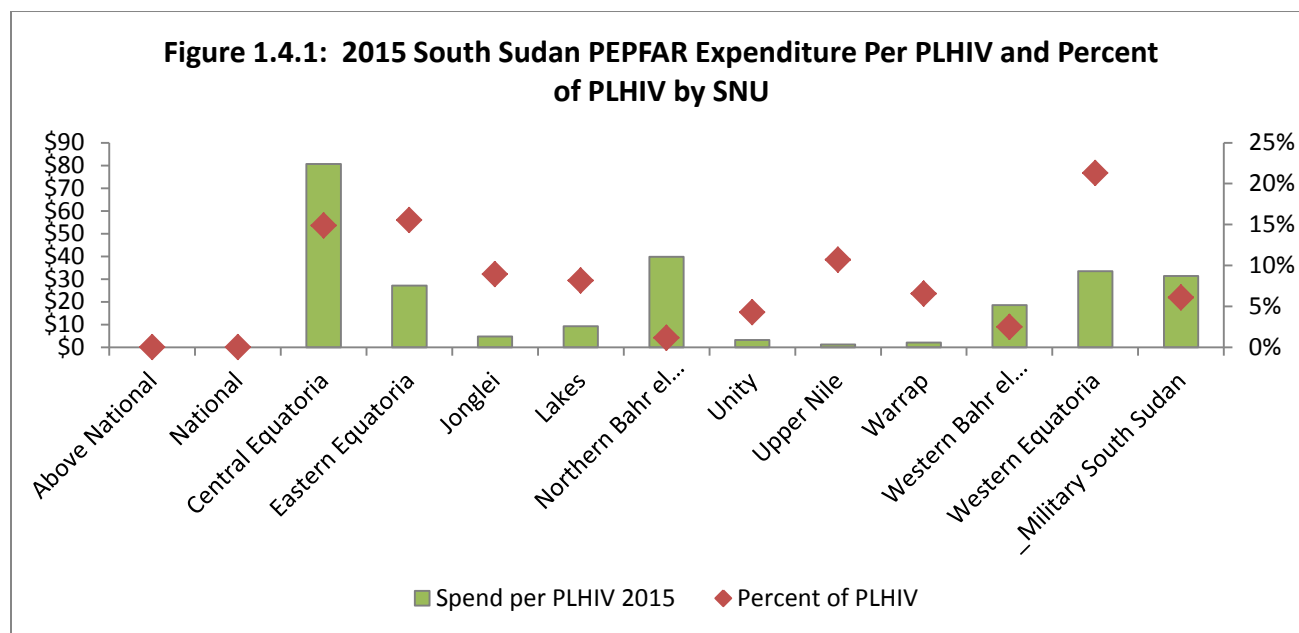
ART coverage is still low in the PEPFAR prioritized scale up aggressive and sustained counties, as reflected in Figure 1.4.2 below. PEPFAR plans to invest in treatment in the five selected scale up aggressive and eleven sustained counties highlighted.

Figure 1.4.2 PEPFAR Priority Counties FY17 and ART coverage FY15
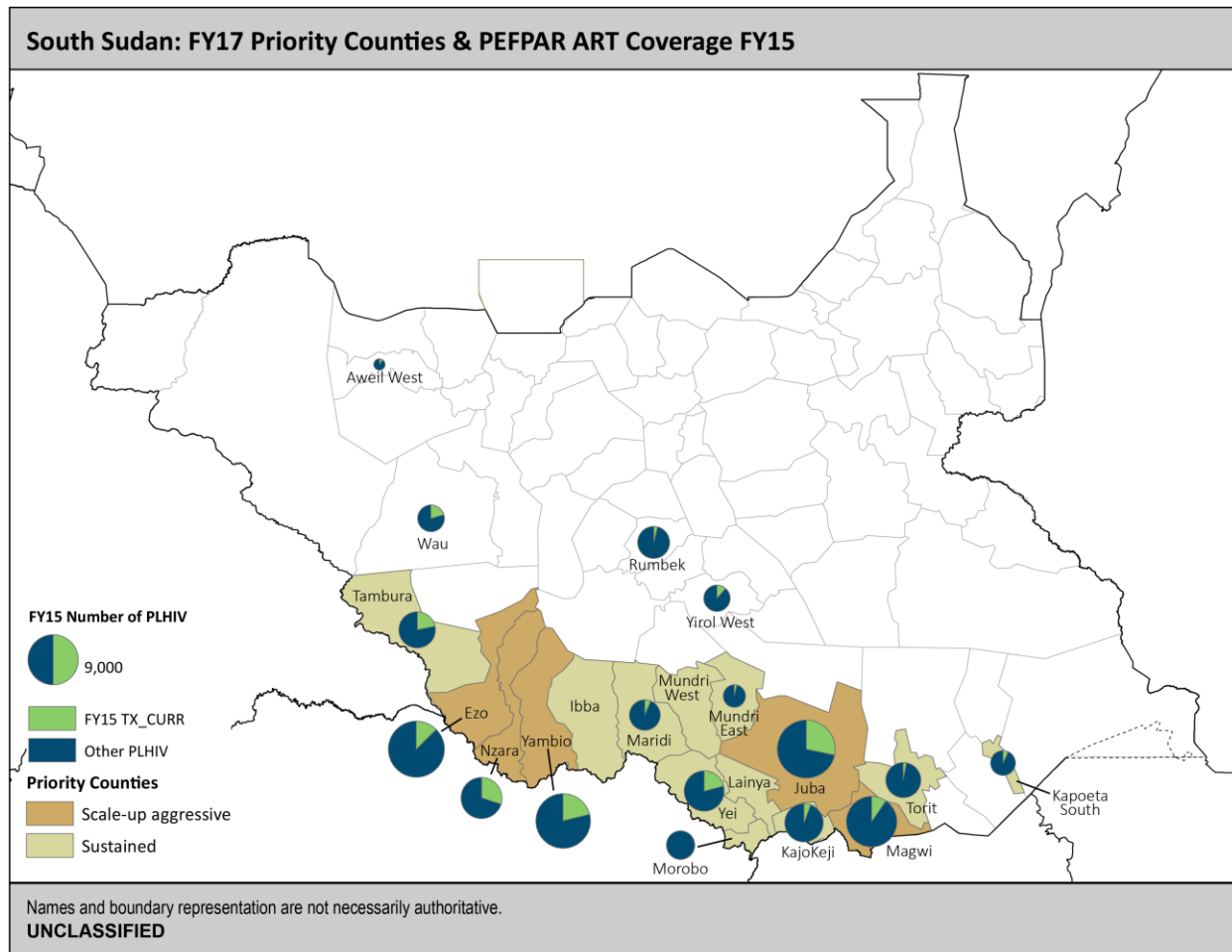
1.5 Stakeholder Engagement

PEPFAR South Sudan developed a 5-year Strategic Plan, which was finalized in December 2013, with input from stakeholders, and was intended to support the South Sudan HIV National Strategic Plan (NSP). This collaboration has created a strong technical footing for the PEPFAR strategy and has not only endured the ongoing conflict, but has helped in the fight to control the HIV epidemic.

In COP16 planning, consistent with guidance to UNAIDS, PEPFAR engaged the RSS UNAIDS office to organize and co-convene a stakeholders meeting. The participants of the one-day stakeholders meeting were drawn from government entities (South Sudan AIDS Commission (SSAC) and Ministry of Health (MOH); UN Agencies (UNDP, WHO, UNICEF, and UNAIDS), local and international NGOs, and CSOs. UNDP is the principal recipient of funds for HIV from the Global Fund and occasionally presents the views of the Global Fund since it does not have a presence in country.

Prior to the meeting, PEPFAR circulated the redacted version of the COP15 Strategic Direction Summary (SDS), Data Pack, the POART and the APR performance for FY 15. During the meeting, a number of presentations were made by the RSS PEPFAR team. These presentations included, among others, an overview of the PEPFAR COP16 process, COP16 priorities, APR performance for FY15 by program area, and the role of civil society in advancing the HIV response, both in South Sudan at large and within PEPFAR projects specifically. All these were followed by question and answer sessions, during which the stakeholders provided their comments, suggestions, and recommendations.

The private sector was not represented in the stakeholders meeting since they are not effectively organized in country.

As a key donor for HIV, the PEPFAR team is well poised among the MOH, SSAC, civil society groups, and key stakeholders to advocate for using data for decision-making, increasing public transparency of information, and establishing meaningful engagement of the community and local government in the delivery of HIV services. In turn, stakeholders have been an integral part of the planning process for COP15 and now COP16, including prioritization of services in key locations and for populations with the highest burden of HIV.

As a result of feedback from CSO representatives, PEPFAR has formalized engagement of PLHIV networks to operationalize new service delivery models in COP16. PEPFAR will provide national level support to two PLHIV civil society networks/organizations to further their role in providing guidance and aligning strategies to operationalize new models of service delivery.

2.0 Core, Near-Core and Non-Core Activities

RSS PEPFAR determined core, near-core and non-core activities through a series of steps that started with stakeholder and headquarters engagement and culminated in a five year PEPFAR strategic plan. The PEPFAR strategic plan aligns itself to the national HIV/AIDS strategic framework 2013-2017. The plan focuses on geographic locations with the highest burden of the HIV epidemic, and prioritizes activities that will lead directly to epidemic control. It also capitalizes on PEPFAR core strengths. Site-level core activities were determined for HTC, care and treatment, prevention, and laboratory services. At the sub-national and national levels, core activities focus on direct service delivery (DSD) to improve service quality, technical assistance (TA) to support the roll-out of systems to scale-up service delivery along the continuum of 90-90-90, support efficient supply chain management, and strengthen monitoring and reporting. Near-core activities center on laboratory systems strengthening, community-based prevention, capacity building for civil society, organizational management and components of strategic information (SI). In FY17, all these systems will focus specifically on scaling up the 2015 WHO and PEPFAR guidance to "Test and START" all PLHIV on treatment.

More detail for which program area elements were classified as core, near-core, or non-core is included in Appendix A.

3.0 Geographic and Population Prioritization

PEPFAR South Sudan will prioritize activities in the three states with the highest HIV burden: Western Equatoria State (WES), Eastern Equatoria State (EES), and Central Equatoria State (CES); together, these three states represent 44% of all PLHIV nationally. Technical assistance for treatment that was previously supported by PEPFAR in the country's other seven states will be mostly transitioned to Global Fund under COP16; this decision was made based on the high cost of service delivery and low number of beneficiaries (low yield) in these states. Three high volume treatment sites will continue to receive PEPFAR TA for service delivery improvement through FY17 to ensure quality of care. Patients on ART in these seven states contributed only 7% of the total number of patients on RSS ART in 2015.

The overall ART coverage in 2015 remained extremely low in all three states (WES at 16%, CES 16%, and EES 4%). In 2015, there were only 12,874 people on ART in these three states. In order to reach 80% ART coverage (saturation) for all 106,439 PLHIV in these three priority states, an additional 72,277 PLHIV would need to start treatment, which is not feasible given the nascent state of South Sudan's HIV program, the difficult operating context in country, and available resources.

Scale-up aggressive SNUs represent the five counties with the highest numbers of PLHIV in the country, estimated at a total of 49,198 PLHIV or 25% of all RSS PLHIV, making them the top priority for PEPFAR programming in COP16. The treatment target in these counties is 20,206, which is an increase of 106% from FY2015 results of 9,785 on ART. The overall ART coverage based on all PLHIV in these scale up aggressive SNUs will reach 41% in 2017 compared to 24% in 2015 (excluding military populations). Thus, although 80% ART coverage will not be achieved, significant progress is anticipated in these SNUs.

A further 19% of all PLHIV live in the eleven sustained SNUs. Among the sustained SNUs, five counties with the highest numbers of PLHIV will also be targeted for significant growth in treatment coverage. The focus counties and relevant data are presented in table 2.1.1 below.

The data for the SNU priority determination was developed from 2012 ANC sentinel surveillance, 2014 Spectrum estimates, and PEPFAR HTC and PMTCT program data. For counties that did not have a health facility participating in the 2012 ANC sentinel survey or PEPFAR service delivery (generally more rural counties), ANC estimates from neighboring health facilities were halved, with the assumption that prevalence is lower in rural areas. This approach has proved useful in SNU prioritization and target setting in the absence of population-based HIV prevalence data.

Table 2.1.1: Disease Burden by County and Planned Aggressive Scale up and Sustained ART Coverage in FY 2017

County	PLHIV	APR2015 TX_CURR	APR2015 TX_CURR PLHIV Coverage	FY17 TX_CURR Target	FY17 TX_CURR PLHIV Coverage
Juba County	12,023	3,396	28%	8,182	68%
Ezo County	11,212	1,811	16%	2,171	19%
Yambio County	10,698	3,929	37%	4,813	45%
Magwi County	9,180	884	10%	1,888	21%
Nzara County	6,085	1,826	30%	3,152	52%
Scale Up Aggressive Total	49,198	11,846	24%	**20,206**	**41%**
Yei County	5,775	1,212	21%	2,895	50%
KajoKeji County	5,273	584	11%	458	9%
Tambura County	4,692	1,020	22%	2,291	49%
Torit County	4,436	126	3%	250	6%
Maridi County	3,381	212	6%	321	9%
Morobo County	2,908	3	0%	185	6%
Lainya County	2,670	0	0%	11	0%
Kapoeta South County	2,200	148	7%	225	10%
Mundri West County	1,847	0	0%	3	0%
Mundri East County	1,806	66	4%	100	6%
Ibba County	1,620	0	0%	7	0%
Sustained Total	36,608	3,371	9%	**6,746**	**19%**
DoD SNU (Scale Up Aggressive)		1,516		5,675	
TOTAL (scale up aggressive and sustained)	**85,806**	**15,217**	**18%**	**32,627**	**38%**

County	PLHIV	APR2015 TX_CURR	APR2015 TX_CURR PLHIV Coverage	FY17 TX_CURR Target	FY17 TX_CURR PLHIV Coverage
Yirol West County	2,513	296	12%	777	31%
Rumbek Center County	3,677	140	4%	202	5%
Wau County	2,557	523	20%	639	25%
Other Total (TA Support)	8,747	959	11%	1,618	18%
ALL TOTAL	94,553	17,692	19%	34,245	36%

PEPFAR South Sudan intends to apply 51% of its COP16 budget on care and treatment in order to scale up ART coverage and provide ART to 34,245 people by the end of FY2017. PEPFAR South Sudan's ability to achieve these targets will depend on improved security in the Equatoria states and leveraging of Global Fund commodities.

Given the overall low coverage of treatment in South Sudan, PEPFAR activities will continue to focus on the general population, along with specific programs for pregnant and lactating women (Option B+), key populations, and the military.

KEY POPULATIONS: Female Sex Workers (FSWs) and Men who have Sex with Men (MSM)

In COP16, PEPFAR will continue to support focused programming for female sex workers. Current HIV prevalence among FSWs is estimated at 25%; the high HIV prevalence within this key population, as well as their role as a driver of the HIV epidemic makes them an important priority for PEPFAR. In addition to supporting the full continuum of prevention, care, and treatment services targeting FSWs in Juba, Nimule, Yambio, and Yei, PEPFAR is also currently supporting a Bio-Behavioral Survey (BBS) of FSWs in Juba. The results, which will provide better information on prevalence, access to treatment, and behaviors that affect HIV prevention among FSWs, are expected in Q4 of FY16 and will guide COP17 planning.

In COP16, PEPFAR South Sudan will also integrate activities to identify and provide services to MSM within the FSW program in Juba. Little is currently known about the size of or the HIV prevalence among the MSM population in South Sudan.

PRIORITY POPULATION: Military

Since its establishment in 2006, the Sudan Peoples' Liberation Army (SPLA) HIV/AIDS Secretariat has played a significant role in efforts to reduce the impact of HIV, not only among the military,

but also within the wider population. The RSS military remains a highly mobile priority population, and studies have shown the military contains the biggest clientele for sex workers, contributing 34% of new HIV infections (Modes of Transmission Study, 2013, MOH). A Bio-Behavioral Surveillance Study (BBSS) conducted in 2010/12 found the military HIV prevalence to be 5%, substantially higher than the adult population prevalence of 2.7% (ANC surveillance, 2012).

Of the estimated 12,500 PLHIV among the military, only 10% have been identified, and treatment coverage is even lower at 7%. In FY15, 2,736 HIV tests were conducted among the military, and 281 HIV positives were identified, a positivity yield of 10%.

Juba Military Hospital (JMH) is currently the only military health facility providing treatment services for military within the country. There is a substantial unmet need for ART provision within the military, with an additional 8,510 PLHIV required to reach the important threshold of 80% ART coverage. In COP16, PEPFAR will support the SPLA HIV/AIDS Secretariat to roll out Test and START both at JMH and through the strategic deployment of mobile ART teams to increase ART coverage for the military population outside of Juba. With the recent formation of the Transitional Government of National Unity, Juba is undergoing a process of demilitarization and both SPLA-IG and SPLA-IO troops are being relocated to eight (8) cantonment sites approximately 25 kilometers outside of Juba. PEPFAR will support the SPLA HIV/AIDS Secretariat with clinical training, commodities, and logistics support to take advantage of this opportunity to reach both forces with HIV testing and counseling services and enroll an additional 2,000 military PLHIV on ART.

PRIORITY POPULATION: Internally Displaced People (IDPs)

In COP16, PEPFAR will support comprehensive HIV services within the Juba Protection of Civilians (POC) site. The ongoing conflict in South Sudan has displaced approximately 1.6 million people, and many of these IDPs are currently seeking shelter in POC sites throughout the country. The Juba POC site has an estimated population of 28,000, and an HIV prevalence of 3.5% among pregnant women (ANC yield) and 7.7% among the general population. With this higher than average HIV prevalence, as well as the opportunity to reach a significant number of people within a confined environment where health services can be made readily accessible, the Juba POC site offers a unique opportunity to rapidly approach the 90-90-90 targets within a specific targeted population.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Within the five Aggressive Scale-up SNUs, RSS PEPFAR will initiate 13,150 new PLHIV on treatment in FY 2017 and provide HIV testing for 165,943 individuals through VCT, CBCT, PITC,

and PMTCT services, as detailed in Table 4.1.1 below. These targets were derived by setting county-level targets for ART coverage, and then utilizing historical HIV testing yields to determine the number of HIV tests that would need to be performed in order to reach these targets. In addition, the team also considered that all active pre-ART patients would be transitioned to ART in FY17 as Test and START is initiated. In reaching COP16 targets within the Aggressive Scale-up SNUs, 75% of PLHIV will be identified, 73% of those identified will be on treatment, and 70% of those on treatment will be virally suppressed (based on proxy of retention). Although the program will not be able to reach saturation in FY17, these targets still represent considerable scale-up of treatment within these priority counties and will set the stage for saturation in coming years.

Given extremely low access to health services in general, reaching the first 90 remains a significant challenge. In order to make significant strides towards epidemic control, in addition to targeting the general population in the five highest prevalence counties within the three priority states, RSS PEPFAR has prioritized several important program areas including PITC (inside TB clinics, under 5 clinics, and STI clinics), PMTCT, key populations (FSW and MSM), and priority populations (clients of sex workers and the military) with the goal of efficiently identifying HIV positive clients in these populations and effectively linking them to care and treatment services (Table 4.1.2). In addition, under COP16, RSS PEPFAR will utilize new approaches, including targeted social and behavior change communication (SBCC), index testing, and outreach services, to increase uptake of HTC.

To accelerate progress on the second 90, in FY17, PEPFAR will provide intensive direct assistance and technical support to all existing treatment sites in the Equatoria states while also supporting the initiation of new treatment centers at lower level primary health care centers (PHCCs). Intensive technical support will be provided to the MOH to expand pediatric ART and EID services. Intensive support will also be provided to the SPLA to scale up ART provision at Juba Military Hospital and to establish two additional treatment sites for the military and others. Additionally, RSS PEPFAR will focus on transitioning all active pre-ART patients to ART. All of these activities will also be supported by increased support for PLHIV to promote improved adherence and retention. PEPFAR estimates an increase in the number of current PLHIV on ART from 11,846 in APR15 to 20,206in FY17 in the Aggressive Scale-up counties (excluding Military) (Table 4.1.1). This represents an increase in coverage from 24% to 41% and would be a substantial accomplishment given South Sudan's severe infrastructure constraints and extremely limited human resources supply, as well as the ongoing conflict.

Implementing these high impact interventions will result in a large number of people being able to access life-saving ART. To support this increase in FY17, PEPFAR will address infrastructure and human resource challenges, including through support for task shifting. New service delivery models will be adopted to ensure sick patients are seen at the hospital and healthy patients are given multi-month ARV scripting to reduce the burden on both the patients and health facility staff. Drop-in centers and peer-based approaches will be used to provide key population-friendly services. Community support systems will be strengthened to improve adherence and retention.

The ability to achieve these targets will depend on the availability of and access to ARVs through PEPFAR and Global Fund. PEPFAR will continue to work closely with the MOH, WHO, and UNDP/Global Fund to conduct joint quantification and communicate the required timelines and budgets to ensure a steady supply of commodities. The program will also utilize the PEPFAR-supported pharmaceutical dashboard to actively monitor stock status.

More generally, the success of COP16 implementation will depend on continued close collaboration with the Ministry of Health, SSAC, Global Fund, and other RSS stakeholders. In addition, PEPFAR's ability to reach the targets will depend on improvements in both the political and economic context in country.

As feasible given the security context in South Sudan, periodic Site Improvement and Monitoring System (SIMS) visits will be conducted in new and high-volume sites. SIMS visits will be conducted by USG staff in sites in Juba, and visits to sites outside of Juba will be done either by a third-party contractor or USG staff, depending on the security context.

Table 4.1.1 ART Targets in Aggressive Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (FY16)	Additional patients required for 80% ART coverage	Target current on ART in FY 17 (TX_CURR)	Newly initiated in FY 17 (TX_NEW)	ART Coverage (APR17)
SCALE-UP AGGRESSIVE						
Juba County	12,023	3,005	6,613	8,182	5,723	69%
Ezo County	11,212	1,811	7,158	2,171	1,313	19%
Yambio County	10,698	3,929	4,630	4,813	1,536	45%
Magwi County	9,180	1,121	6,223	1,888	740	21%
Nzara County	6,085	1,934	2,934	3,152	692	52%
DOD		2,790		5,675	3,146	
TOTAL	**49,198[11]**	**14,590**	**27,558[12]**	**25,881**	**13,150**	**52%**

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Counties

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) TX_NEW
Adults			
Pre-ART moving to ART			1,367
HIV+ TB patients not on ART	1,175	149	120
HIV-positive pregnant women Civilian	25,524	1,778	955
HIV-positive pregnant women-	2040	28	22

---

[11] Excludes military, as their PLHIV numbers are also included in county estimates
[12] Excludes military, as their PLHIV numbers are also included in county estimates

Millitary			
Other HIV positive identified through VCT/PITC and CBC excluding PMTCT, TB, key and priority population	69,205	8,277	7,684
Other priority and key populations _FSW/MSM	3,843	961	865
Other priority and key populations _Millitary	53,808	3,612	3,146
Pediatrics			
Clinical care pediatrics not on ART			481
HIV exposed infants	1247	36	36
Provider Initiated Testing	9,010	840	760
TOTAL	165,943	15,681	15,706

KEY POPULATIONS

With the goal of increasing ART coverage among populations with a high likelihood of transmitting HIV, RSS PEPFAR will target FSWs in four major towns within the Equatoria states and provide a full spectrum of services including HIV testing, active linkage to care and treatment for those who test positive, and prevention services for those who test negative. Additionally, key population programming will emphasize supportive services to ensure continued retention and adherence of HIV-positive FSWs on ART while addressing structural challenges such as violence against providers and beneficiaries. Children of FSWs will also be considered as a priority group for orphans and vulnerable children (OVC) programs, and referrals between FSW and OVC interventions will be included. In the Aggressive Scale-up SNUs, PEPFAR intends to reach 4,270 FSW and 50 MSM, ensure that 90% are tested for HIV (n= 3,888), and 94% of those tested positive (n = 972) are linked to care and treatment.

PMTCT

In order to achieve epidemic control, RSS PEPFAR has prioritized PMTCT services as a means to efficiently identify HIV positive pregnant women and link them to care and treatment services within the MNCH platform (Table 4.1.2).

PRIORITY POPULATIONS (Clients of sex workers)

Clients of FSWs, and the military, will be targeted with a focus on support for combination prevention activities. However, RSS PEPFAR does not currently have population size estimates of FSW clients and therefore targets were not calculated for this priority population.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts				
Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	*VMMC_CIRC* (in FY17)	Expected Coverage (in FY17)
Military (Age 19-49)	250,000	No data	0	0
Total/Average	**250,000**	No data	**0**	**0**

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
KP_PREV	FSW: 5,642[13]	N/A	4,720
Total	**5,642**	**N/A**	**4,720**

Table 4.1.5 Targets for OVC and Linkages to HIV Services			
	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT
Juba County	No data	4,000	N/A
TOTAL	**No data**	**4,000**	**N/A**

4.2 Priority and Key Populations

Article 19 of the RSS interim constitution expressly criminalizes commercial sex work (prostitution). Under Section 252 of the penal code, the following acts are deemed as punishable offences by law: soliciting, living off or facilitating prostitution; keeping a brothel; and procuring and coercing or inducing persons for the purpose of engaging in sexual conduct. The constitution and penal code remain silent on other key populations including MSM, although there are reports of extreme violence against these groups by society and security personnel.

This legal environment has continued to drive sex workers into hiding, denying them critical services and hindering the ability of HIV-positive persons engaged in sex work from accessing and adhering to ART. Moreover the current conflict and economic situation have driven many young girls and women into destitution, and subsequently, commercial sex work. In FY17, PEPFAR will continue to actively look for and reach key populations with critical services to mitigate their risk

---

[13] Estimate for Juba and Yambio only

of HIV. The strategy will deploy the human rights approach of "health for all," which is stipulated in the national constitution and articulated in the RSS Health Sector Development Plan.

In FY17, the program will continue to expand access to FSW and MSM by expanding the network of peer counselors and in identified hotspots within four major towns (Juba, Nimule, Yei, and Yambio), with the aim of creating stigma free zones characterized by three essential components:

a) High quality services
b) Trained and sensitive staff
c) "Savvy" consumers: ensure FSWs are knowledgeable about their own health and safer to conduct business

The program will first identify gaps in the HIV prevention, care, and treatment cascade among FSWs in each hotspot area. Once gaps are identified, targeted services and TA along the continuum of HIV prevention, care and treatment will be provided to service delivery site service providers, including the utilization of drop-in-centers/safe spaces in Juba, Yambio, Nimule, and Yei.

The following major activities will be implemented in each hotspot to improve the continuum of HIV prevention, care and treatment for FSWs and MSM:

- Targeted mobile HTC services for FSWs and MSM
- Implementation of Test and START for FSWs and MSM
- Multi-month scripting involving medicine pick up by one peer for a self-selected group
- Community-based outreach, including FSW Peer Education and Peer Navigators program, inter-personal communication and community mobilization
- Orientation and training of health care workers to provide services to FSW
- Capacity development of local organizations to build local FSW capacity to develop and implement their own programs
- High quality monitoring through supportive supervision for outreach and peer education/peer navigators and the ongoing usage of intervention standards
- Implementation of a unique identifier system

In addition to creating high quality services, demand for comprehensive prevention, care, and treatment services will be fostered through a variety of activities aimed at education and self-empowerment of FSWs, such as community mobilization, community-based service provision through edutainment activities, and by training select PLHIV peer educators to serve as peer navigators for their FSW peers living with HIV.

Drop-in centers (DIC)

In FY17, PEPFAR will expand the drop-in center model to provide safe and non-discriminatory access to services by FSWs and MSM. Additional drop-in centers will be opened in Yei, Yambio, and Nimule to allow peer educators to assemble and plan weekly activities, and to offer HTC, STI

treatment, FP and ART services. DIC staff will also conduct mobile outreach HTC for FSWs and refer for ART.

4.4 Preventing Mother-to-Child Transmission (PMTCT)

In FY 2015, RSS PEPFAR worked towards expansion of its support to PMTCT sites, prioritizing efforts to scale-up Option B+ at *all* PEPFAR supported PMTCT sites using models of integration of PMTCT services to ensure at least 90% of ANC clients are tested for HIV and 90% of those diagnosed as HIV positive are registered in care and have access to ART.

In COP16, RSS PEPFAR will strengthen and expand on the successes of COP15. PEPFAR plans to provide PMTCT services in 27 PEPFAR supported PMTCT sites. Fourteen of these PMTCT sites will be in five counties classified as scale-up aggressive SNU, and 13 PMTCT sites will be in eight of the sustained SNUs.

These selected counties in the Equatoria states will also be targeted for increased uptake of ANC services, HIV testing, routine PITC to pregnant women and their partners, counseling on repeat testing for those testing negative, primary prevention through HIV education, and voluntary family planning counseling and commodities provision. Testing during labor and delivery as well as the post-natal period will be increased to identify women who seroconvert or who did not receive ANC services. Infant feeding counseling will be emphasized along with exclusive breastfeeding for the first six months.

Specifically, in FY17, RSS PEPFAR will expand PMTCT option B+ services to reach more women and upgrade the majority of the current high volume PMTCT sites to provide comprehensive adult and pediatric ART services. This will support the decentralization of ART services and improve access for spouses and children.

In addition, PEPFAR will ensure engagement of county and state leadership in the management of the PMTCT program and all HIV services at primary health care centers. This engagement will ensure that PEPFAR programming utilizes existing MOH systems, and that MOH leadership in HIV programming continues to increase.

Family planning/HIV services integration

To ensure that the reproductive health needs of all mothers and their spouses are addressed, family planning will be integrated into all PMTCT programs. During training for health workers, family planning will be included in all modules to ensure that providers are able to address the unmet needs of family planning for all HIV positive pregnant/lactating mothers.

The family planning component for all PMTCT programs will be coordinated with USAID-supported programs, which provide essential services within all health facilities in the three Equatoria states. The PEPFAR team will also participate in forecasting and quantification

exercises and leverage family planning commodities supplied by both USAID and UNFPA as a way to support prong 2 of PMTCT.

4.5 HIV Testing and Counseling (HTC)

In COP16, PEPFAR plans to provide comprehensive HTC services targeting all entry points in facilities that it supports.

PEPFAR will continue to strengthen and expand PITC through its partners, as well as work with the MOH to roll out a nationwide PITC program with a focus on linkages to care and treatment services. Emphasis will be placed on increasing PITC services in hospital-based children's wards (in-patient and out-patient), TB clinics, outpatient departments, and medical wards. Re-testing of HIV-positive individuals before ART initiation will also be emphasized.

HTC activities will also focus on generating community demand for HIV testing and on increasing the numbers of individuals tested in high burden areas who present at sites for other health services. PEPFAR partners will continue to support campaigns to encourage couples testing and expand services that offer hours convenient for couples. HTC programs will adopt innovative approaches, such as telephone tracking, to strengthen the referral system of newly identified HIV positives to care and treatment.

Special focus will be made to expand access to early infant diagnosis (EID) of HIV; and testing for key and priority populations, including sex workers and females 15-24 years of age (including university students). PEPFAR will support targeted outreach and mobile HTC services to key and priority populations with direct linkages to care and treatment sites.

All PEPFAR supported HTC sites will participate in quality assurance (QA) activities to ensure minimum standards of quality and accuracy of results. Program monitoring activities will be implemented including TA, SIMS visits to partner sites, quarterly reporting, monthly PEPFAR TWG meetings, regular counselors' supportive supervision meetings, and client exit interviews.

In FY 17, PEPFAR will support HTC at 49 sites, excluding the military. PEPFAR will continue to support a total of 28 sites in the aggressive scale-up counties and 21 sites in the sustained counties.

4.6. Facility and Community-Based Care and Support

In COP16, PEPFAR partners will implement the WHO 2015 guidelines of Test and START, where all HIV-positive patients will be initiated on lifelong ART. PEPFAR will continue to support a standard package of care and support services at PMTCT and ART sites. PEPFAR support will concentrate on the three highest burden states (i.e., Greater Equatoria).

RSS PEPFAR will focus the care and support portfolio to:

1. Improve retention in care for ART patients, engaging PLHIV as agents for community mobilization to ensure all active pre-ART patients are enrolled on ART as recommended by the WHO 2015 guidelines.
2. Improve linkages to care services from the entry points, i.e., HTC/PITC and PMTCT. Efforts are in place to improve linkages to care from HTC/PITC and from care to community-based services. Partners will formalize the role of PLHIV groups and mother-to-mother/mentor mothers support groups to strengthen linkages between facility and community-based services. In FY 2017, PEPFAR implementing partners will provide direct comprehensive HIV services, including provision of TA to HIV care and treatment sites and work with the site staff, MOH, and key stakeholders to address the chronic challenges in linking HIV positive patients identified at HTC, TB and PMTCT sites.

PEPFAR will support the above programming in COP16 through partnerships with the MOH and other stakeholders. PEPFAR-supported sites will also receive support for essential health services, including elements of a more comprehensive family planning program, through USAID and other donors. It is expected that PEPFAR will leverage those programs to help meet the needs of PLHIV in need of care and support services while simultaneously helping those programs expand their reach.

4.7 TB/HIV

In COP16, PEPFAR will continue to work with the national TB program and other stakeholders to improve collaboration between TB and HIV programs and to ensure that all TB patients are tested for HIV and that all who test positive for HIV are appropriately linked to care and treatment services. The TB screening services and referrals will be provided in 30 sites. Eighteen of these will be in scale up aggressive counties with 12 sites in sustained counties.

PEPFAR will work to strengthen linkages and referrals between TB and PMTCT/ART sites as well as develop new collaborations with TB wards to test TB patients for HIV.

All PEPFAR PMTCT and ART sites will be encouraged to continue provision of TB screening among PLHIV (using the TB screening questionnaire), ensure diagnostic follow-up for PLHIV with presumptive TB, and conduct active referrals to TB treatment for PLHIV with TB disease.

RSS PEPFAR will continue to work with the national HIV and TB programs to develop policies, on-site training, and ongoing mentoring for clinical staff to strengthen TB/HIV program monitoring and evaluation (M&E), ensuring that TB/HIV indicators are captured by both monitoring systems. The team will also support activities to improve integration of TB and HIV programs at national, state, county and health facility levels. This will include active coordination with non-PEPFAR USAID-supported TB programs.

4.8 Adult Treatment

RSS PEPFAR is working closely with the MOH, WHO, Global Fund and other stakeholders, to adopt the 2015 WHO guidelines ("Test and START"). PEPFAR will also emphasize re-testing for HIV-positive patients before initiation of ART. The MOH has provided a letter of endorsement to show their commitment to Test and START.

With RSS PEPFAR support in the Aggressive Scale-up SNUs, 12,628 new patients will be initiated on ART in FY 17 (11,232 at treatment centers and an additional 1,396 through Option B+); there will be a total of 22,913 patients on treatment in the Aggressive Scale-up SNUs in FY 17. All "Active" Pre-ART patients will be shifted to ART.

In FY17, RSS PEPFAR will provide direct service delivery to 29 ART sites (including Juba Military Hospital (JMH)). Seventeen of the ART sites will be from the scale up aggressive counties, with 12 ART sites from sustained counties.

RSS PEPFAR will work to improve health care providers' capacity, including capacity building at the national and state levels, to deliver high quality family-centered HIV care and treatment services to adults and children living with HIV.

In order to scale up and assure the technical quality of the national HIV care and treatment program, PEPFAR will provide TA at national and facility level.

National TA will consist of: 1) secondment of staff, technical support, and funding to support and facilitate MOH to revise the National ART Guidelines and National ART Standard Operational Procedures (SOPs); 2) Organizing and facilitating a national launch of the developed ART guidelines and SOPs; 3) Organizing, facilitating, and funding the Annual National HIV Care and Treatment Review and Planning Meeting, which includes the MOH, the State Ministries of Health, hospital directors, and ART provider in charge at each treatment site; and 4) in collaboration with MOH/WHO, organizing and facilitating adult and pediatric HIV management courses twice annually (for 3 sites).

Facility based TA will consist of: 1) TA at three treatments sites (Mary Immaculate Hospital (Mapourdit), Rumbek Hospital, and Wau Teaching Hospital; also see 5.1), including supportive supervision and mentorship; and 2) funding through a PEPFAR IP to provide TA to sites no longer being supported in COP16 including new ART sites in aggressive scale-up counties in the Equatorias which will jointly be identified by MOH and PEPFAR.

In COP16, the RSS PEPFAR program will emphasize:

- Test and START: All HIV-positive patients will be enrolled for treatment (ART) after re-testing

- CD4 count will remain the main means of patient monitoring throughout most of RSS, but viral load monitoring will be introduced in Juba
- Expanding access to ART through decentralization of ART services to 13 new sites, and providing mobile outreach services for low-volume and remote areas
- Provision of differentiated ART service delivery model with multi-month scripting/ prescriptions for stable patients
- Increasing access to ART and ART coverage for patients with TB/HIV, FSW, young women and children to reach treatment targets
- Providing additional on-site training and mentoring for clinical and laboratory staff, including support to nurture a multidisciplinary team approach to patient management
- Supporting collaboration and partnership between various clinical services, and between government service providers and NGOs, by organizing partners' meetings during site visits to local facilities
- Improving supply chain management of ARVs and drugs for opportunistic infection (OI) prophylaxis and treatment, as well as laboratory supplies. Support under COP16 will include TA to support quantification and financial analysis/planning for Test and START, as well as for developing an implementation plan for operationalizing multi-month dispensing
- Developing and introducing evidence-based approaches to increase PLHIV access and adherence to HIV treatment and care services, such as community support groups, mobile text messaging appointment reminders to improve clinic attendance, integrated TB/HIV and other services
- Improving retention in care for ART patients by utilizing community support groups and other innovative strategies to keep people in care and ensure they are started on ART. PEPFAR treatment partners will provide direct financial and capacity strengthening support to local PLHIV organizations to operationalize innovative approaches to enrolling PLHIV in care and treatment. This may include engagement of PLHIV groups in index testing and linkages to facilities, quality assurance, adherence support/treatment literacy, and community-based distribution models.
- Supporting harmonization of M&E tools

The above activities aim to improve linkage of PLHIV to ART services, adherence to ART and retention in programs, and support clinicians from ART sites in improving the quality of medical services for PLHIV. To help ensure the quality of these services, PEPFAR USG staff will conduct SIMS visits to all PEPFAR-supported ART sites, as feasible based on the local security context. During the routine mentorship visits, PEPFAR-supported Implementing Partners (IPs), in partnership with MOH staff, will conduct working meetings with all staff at each ART/PMTCT site to review and discuss quality of treatment services using the standard of care and to discuss progress, existing challenges, and ways to improve service delivery. Mentors will provide clinical mentorship to ART site staff for clinically challenging patients, discuss existing challenges in ensuring patient retention in care and adherence to ART, and identify the most suitable solutions.

As required, phone calls to ART staff on topics such as treatment, care, and laboratory services will be provided. As part of the TA support package, PEPFAR will assist the country in developing a formal quality assurance and improvement program and provide support to MOH and partners to sustain HIV clinical programming.

4.9. Pediatric Treatment

As mentioned above, the MOH is in the process of adopting the 2015 WHO guidelines, which require all HIV positive individuals be initiated on ART for life. This means all children diagnosed as HIV positive will be started on ART based on the regimens spelled out in the 2015 guidelines.

RSS PEPFAR will prioritize pediatric HIV testing, care and treatment within a family centered approach. This is aimed at increasing the ability to find and treat HIV positive children through PITC, PMTCT and ART services.

In COP16, RSS PEPFAR will focus on:

- Improving pediatric HIV case finding by prioritizing routine, systematic HIV testing of all children in high-priority settings: active tracing of infants will be done at the PMTCT setting as well as providing PITC services at the pediatric wards (e.g. in Al Shabah Children's Hospital). Though the country has not started HIV early infant diagnosis (EID), PEPFAR will work closely with Global Fund to ensure the GF procured PCR machine is put into use. Arrangements are also under way to ship EID specimens to Nairobi using a PEPFAR partner. Until the PCR machine becomes functional, PEPFAR plans to emphasize presumptive diagnosis and to establish systems for mother-infant pair follow-up.
- The PEPFAR-supported OVC program will also establish linkages with PEPFAR-supported sites to facilitate HIV testing for OVCs. For OVCs who test positive, the OVC program will also provide support to ensure linkage to care and treatment services.
- Enhanced linkage and retention of children on ART by reviewing the pediatric "cascade" from identification to retention and follow-up of HIV exposed infants and children on ART. PEPFAR will identify and address loss-to-follow-up along the cascade by strengthening community support systems.
- Improving health workforce competencies in providing comprehensive child health services to HIV-infected children, including nutritional assessments, treatment of opportunistic infections, and integration or linkage to routine health services such as immunization.

PEPFAR and its IPs will continue to work with the national programs to develop policies, on-site training, and ongoing mentoring for clinical staff to initiate and maintain children on ART, with periodic supervision by PEPFAR IP medical doctors.

4.10 OVC

The current crisis has worsened the situation of orphans and vulnerable children, at a time when RSS was just beginning to heal from decades of civil unrest. Social networks that exist in the form of families taking care of orphans are stretched to the limit by recurrent fighting, subsequent displacement, and the economic situation the country faces. The economic situation is pushing more families to the edge, forcing young girls, especially in the IDP camps, to engage in risky activities (e.g., transactional sex) to earn money.

In FY17, RSS PEPFAR will prioritize household economic strengthening, psychosocial support, and strengthening parenting for OVCs and their caregiver families. To mitigate the effect of HIV/AIDS, case management will be instituted for beneficiaries entering the program through ART. 90% (about 350) of all children currently on treatment in Juba city will immediately be enrolled into the program. PEPFAR will also ensure access to high quality HTC and linkage to care and treatment for OVCs who are identified to be HIV positive. A time-limited start-up package of consumption support will be provided to prioritized beneficiaries. This support will be used to provide a base of support for the most vulnerable beneficiaries so that they are able to effectively access economic strengthening and educational services. The consumption support will be tied to specified benchmarks agreed between the program and beneficiaries to ensure a clear transition plan is available from the outset.

Given the limited OVC budget, OVC programming will be limited to Juba County. The following groups will be targeted:

- OVC children living among PLHIV;
- Vulnerable children living among the FSW community;
- Children from families of HIV-positive mothers from the PMTCT and care/treatment programs; and
- At-risk adolescents living in the protection of civilian sites in Juba.

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Package of services and expected volume in sustained support locations and populations

In COP16, PEPFAR will continue to support a core package of services in 11 Sustained counties. These 11 counties (Yei, Torit, Kapoeta South, Maridi, Mundri East, Mundri West, Tambura, Kajokeji, Ibba, Lainya and Morobo) are located in the Equatoria states and have a relatively high burden of HIV. In COP16, support to HIV department, MOH will be in the form of TA to the

MOH, such that the MOH can competently provide mentorship and supportive supervision to HTC, PMTCT, and ART sites in the country.

PEPFAR partners will provide support for HTC, PMTCT, and ART in the sustained SNUs. Given that South Sudan's HIV program is still in its early phases, the basic package of HIV services remains quite limited. Therefore, the core package of services that PEPFAR will support in Sustained SNUs is the same as that supported in the Aggressive Scale-up SNUs (with the exception of VL testing); however, the number of sites to be supported is relatively fewer given the lower HIV burden as compared to the Aggressive Scale-up SNUs.

The core package of services will focus on:
- Initiation of Test and START
- Introduction of multi-month scripting for stable patients
- Provider training and on-going clinical mentorship
- PITC
- ARV and CTX procurement/provision for targets above GF forecast
- PMTCT B+
- Patient tracking, monitoring and adherence
- Laboratory monitoring (point of care CD4 in sites that cannot conduct VL testing) and quality assurance systems
- Targeted HR support
- Data verification and monitoring and evaluation support
- Scale-up of HIV testing at TB, pediatric and medical wards
- Index testing with active linkages, particularly in PMTCT, military and urban settings
- Early infant diagnosis with sample transport and result tracking
- Targeting quality improvement focused on retention, stock management and ART monitoring
- Service provision for MSM and FSWs in hot spots

In the sustained SNUs, PEPFAR will provide HIV counseling and testing services to a total of 36,479 individuals, i.e. HTC (28,631) and PMTCT (7,838), and enroll total of 6,440 patients on ART (with PMTCT_ARV contributing 1,316 mothers). (See table 5.1.1 below.)

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group	**Expected result APR 16**	**Expected result APR 17**	**Percent increase (decrease)**
HIV testing in PMTCT sites	9,153	7,838	14% decrease
HTC	39,039	28,641	27% decrease
Current on ART	3,426	6,440	88% increase
OVC	**0**	**0**	**0**

The 88% increase in current on ART is due to new decentralized ART PHCCs planned for 2017 that will provide ART to 1,902 persons, while the older sites operational in 2016 will contribute 4,264 current on ART, representing a 24% increase from their expected 2016 APR results. However, these sustained SNUs, which have a lower number of PLHIV compared to scale up aggressive SNUS, will also have lower ART coverage targets.

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

ART
In COP14 and COP15, PEPFAR provided TA to ART sites primarily supported by the Global Fund. This was done to ensure an ongoing quality of care for those currently on treatment at these sites. Some of these ART sites are outside of PEPFAR's priority high-prevalence states (i.e. in Lakes, Northern Bahr el Ghazal, and Western Bahr el Ghazal states). In COP16, PEPFAR will transition support for these sites to the Global Fund in order to focus on the Aggressive Scale-up and Sustained SNUs. PEPFAR will continue to provide TA for service delivery improvement in three high volume sites outside the Equatorias: Mary Immaculate Hospital (Mapourdit), Rumbek Hospital, and Wau Teaching Hospital.

PMTCT/HTC
PEPFAR's support for PMTCT and HTC has been limited to the three Equatoria states (i.e., Aggressive Scale-up and Sustained SNUs). Therefore, in FY17, there are no sites to transition.

OVC
PEPFAR South Sudan's OVC program is limited to Juba (Aggressive Scale-up SNU). No OVC activities have been or will be implemented in Sustained or Central Support SNUs.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

COP16 represents the beginning of a process to identify and support those systems investments that are most critical to addressing 1) priority programmatic gaps in the clinical cascade (Section 6.1), as well as 2) the implementation of the priority policies of Test and START and new service delivery models (Section 6.2), as articulated in the WHO guidelines and technical considerations. As such, the majority of systems investments, as demonstrated by COP16 proposed activities and budgets, are supportive of the programmatic gaps and priority policies, and are reflected in Sections 6.1 and 6.2. All other systems investments not included in either 6.1 or 6.2 are included in Section 6.3.

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Three key programmatic gaps, aligning with each of the three "90s" have been identified for RSS. Based on the information described above in Section 1.2: Investment Profile, it is critical that PEPFAR, working in collaboration with the Global Fund, support the systems investments described below. While the ultimate goal is for the GoSS to take ownership (including financial) of the HIV program, this is unlikely to be realized for many years.

Programmatic Gap 1: Relative to the total number of PLHIV expected in PEPFAR-targeted counties, very few have been identified.

When looking at progress on 90-90-90 in South Sudan and in the five Aggressive Scale-up counties planned for in COP16, it is notable that the biggest gap is associated with the first 90. There are many broader contextual and structural factors that make access to and utilization of health services in RSS among the lowest worldwide, with only 12% of deliveries taking place in health facilities, and only 53% of women receiving four antenatal care visits (MOH, HMIS Report 2014). As a result, as of 2015, only about 14% of PLHIV nationwide have been diagnosed. At the same time, current reliable population-based data is not available, and program-based health data is limited, which adds an additional challenge to appropriately targeting PEPFAR interventions. There is also incomplete reporting of HIV indicators from health facilities through the MOH District Health Management and Information System (DHIS) to provide realistic subnational unit coverage figures.

In order to address this first programmatic gap, RSS PEPFAR will focus on addressing the four key systems barriers that have been identified: 1) limited implementation of PITC at health facilities; 2) limited availability of population-based data and reliable program data to support evidence-based targeting of HTC in high-prevalence areas; 3) limited reliable program data to track progress towards 90-90-90 and to guide program planning; and 4) low uptake of HIV services due to limited information on HIV and HIV prevention, as well as stigma and discrimination. Only by increasing the pool of potential clients (i.e., those accessing health services), and simultaneously

ensuring high coverage of HTC among these clients (e.g., through PITC), can RSS make meaningful progress towards the first 90.

Programmatic Gap 2: Of the PLHIV who have been identified in PEPFAR-targeted counties, linkages to treatment and strategies to facilitate simplified treatment models and continued retention have been weak and inadequate.

South Sudan's HIV program, especially with regards to treatment services, is still in its infancy. Despite significant scale up in recent years, largely through the support of PEPFAR, the availability of treatment services remains severely limited. While PEPFAR is supporting HTC in 49 sites in FY2016, there are only 18 sites that provide ART services. In addition, numerous challenges to seeking health services (including ongoing conflict, poor road infrastructure, etc.) mean that a significant proportion of clients who test positive for HIV may not return to initiate treatment. These barriers to access, coupled with weaknesses in health worker capacity and lack of systems to track patients, create an environment where linkage to and retention on treatment can be extremely difficult.

In order to address this second programmatic gap, RSS PEPFAR will focus on addressing the five key systems barriers that have been identified: 1) low access to ART clinics; 2) inadequate numbers and skills of health care workers to provide high quality ART services; 3) limited and weak community systems to support PLHIV on treatment; 4) stigma and discrimination resulting in low uptake of services; and 5) inadequate data systems to track retention of patients on ART. PEPFAR will use approaches such as decentralization of ART services to lower-level facilities, increased mobile and community outreach services, and task shifting to increase availability of and access to services, while also employing community support structures and social and behavior change communication (SBCC) to improve adherence and retention.

Programmatic Gap 3: There is a need for a strengthened system to facilitate rollout of quality VLand EID testing, and to use the information to improve programs.

RSS is currently unable to measure progress towards the third 90 given the lack of VL monitoring in country. While estimates of viral suppression can be made based on retention figures, the program urgently needs to implement VL and EID testing in order to align with WHO guidelines and facilitate monitoring of the ultimate effectiveness of the RSS HIV treatment program.

In order to address this third programmatic gap, RSS PEPFAR will focus on addressing the five key systems barriers that have been identified: 1) incomplete infrastructure modifications in the laboratory; 2) lack of a specimen referral system or result transmission system to support movement of samples from facility to testing laboratory and results from testing laboratory to patient; 3) existence of a single machine approved for viral load monitoring using plasma, which limits the ability to provide viral load monitoring to clients in distant facilities; 4) inadequate numbers of skilled laboratory personnel to conduct high quality PCR testing; and 5) lack of a system for collecting and managing VL data. PEPFAR will focus on ensuring the development of a context-specific system that can efficiently ensure regular viral load monitoring for HIV patients

in Juba; in the medium to longer term, this system will be expanded to other geographical areas of the country.

Table 6.1.1 Key Programmatic Gap #1: Relative to the total number of PLHIV expected in PEPFAR-targeted counties, very few have been identified.						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
PITC is not routinely implemented at health facilities.	• Health providers are trained • PITC is routinely implemented in priority SNUs	Sensitization meetings with county health managers to promote expansion and sustainability of PITC	HVCT	*[REDACTED]*	SPPHC RTI CMMB ICAP Intrahealth International	7. Human Resources for Health
		Training on PITC for health providers to support optimized PITC at health facilities (ANC clinic, labor and delivery wards, TB clinic, and under-5 clinics)				
		Regular mentoring and supervision				
		Ensure sustained supply chain for RTKs				
Limited population-based data is available at county level to support evidence-based targeting of HTC in high-prevalence areas.	• AIDS Indicator Survey (AIS) completed • FSW HIV prevalence and bio-behavioral data available for at least 3 towns	Support planning of the AIS, protocol development and approval, budgeting and resource mobilization from other partners, field implementation of the survey including data quality and testing quality control, data analysis, report writing, and dissemination	HVSI	*[REDACTED]*	TBD	13. Epidemiological and Health Data
		Conduct an additional FSW BBS and disseminate findings to support programming Work with the MOH to develop and update HIV/AIDS surveillance and surveys strategic plan	HVSI	*[REDACTED]*	SI TBD	13. Epidemiological and Health Data
Limited reliable program data to track progress towards 90-90-90 and to guide program planning.	• Improved completeness of HIV indicators reporting in DHIS • Improved monitoring of progress towards UNAIDS 90-90-90	County level support supervision and mentoring of M&E officers, data clerks Training of M&E officers, data clerks at county and facility level Support updating, production and availability of MOH HIV/AIDS data collection and reporting tools Support state and national MOH staff to monitor trends in HTC, PMTCT and ART including cascade analysis and dissemination of regular HIV situation updates	HVSI	*[REDACTED]*	SI TBD	13. Epidemiological and Health Data

		Support the SSAC and MOH to update the National HIV/AIDS national strategic and strategic information plans that end in 2017, as well as development of new plans				
Uptake of HIV services remains low due to limited information on HIV and HIV prevention, as well as stigma and discrimination.	• Greater awareness of and demand for available services (including among senior military commanders) • Services for key and priority populations are adapted to their needs and delivered in a respectful manner	Start-up and ongoing support for three drop-in centers for FSWs; advocacy around policy constraints to providing services for FSWs	HVCT, HBHC, HTXS, OHSS	*[REDACTED]*	Linkages	2. Policies and Governance 6. Service Delivery
		Peer outreach for FSWs and MSMs	HVOP	*[REDACTED]*	Linkages	
		Training of health providers on key population-sensitive service delivery	HVOP, HVCT, HTXS	*[REDACTED]*	Linkages	6. Service Delivery
		Engagement of county and state leadership in management of HIV programs at PHCCs	OHSS	*[REDACTED]*	SPPHC CMMB IHI	6. Service Delivery
		Mobile outreach to universities to provide adolescent friendly sexual and reproductive health services, including HIV awareness raising and HTC	HVOP, HVCT	*[REDACTED]*	SPPHC	
		Sensitize commanders on their roles in HIV service delivery among troops	HVOP	*[REDACTED]*	RTI	6. Service Delivery
TOTAL				*[REDACTED]*		

Table 6.1.2 Key Programmatic Gap #2: Of the PLHIV who have been identified in PEPFAR-targeted counties, linkages to treatment and strategies to facilitate simplified treatment models and continued retention have been weak and inadequate.

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Access to ART clinic remains low. There are few clinics providing ART to PLHIV. Many clinics which provide HTC do not provide ART.	• Increased number of health facilities providing ART services • Improved systems for reaching populations in remote locations and those displaced by conflict	Decentralize ART to primary health care centers to make services more accessible to populations	HTXS	[REDACTED]	SPPHC CMMB IHI	6. Service Delivery
		Conduct outreach services to reach low volume remote locations	HTXS	[REDACTED]	SPPHC CMMB	
		Conduct mobile multidisciplinary team outreach to remote military garrisons	HTXS	[REDACTED]	RTI	
		Engage MOH and partners in implementation of Test and START	HTXS	[REDACTED]	SPPHC, ICAP, IHI, CMMB, RTI	2. Policies and Governance
Inadequate number and skills of available health care workers to provide high quality ART services, including managing OIs at all levels	• Policy for nurse-initiated ART is developed, approved, and implemented at primary health centers	Support Ministry of Health in developing/adopting policy	HTXS	[REDACTED]	SPPHC ICAP	7. Human Resources for Health
		Train nurses on ART services; mentoring and supportive supervision				
		Support in-service training of clinical officers, nurses, dispensers, counselors, and lab technicians to improve client enrollment and management	HTXS	[REDACTED]	RTI, ICAP, CMMB, SPPHC, IHI	
	• Four seconded staff to the MOH recruited and support the HIV department (MOH)	Support MoH staffing needs and ensure high quality staff in MoH	HTXS	[REDACTED]	ICAP	
Community systems to support PLHIV on treatment are weak and limited.	• Strengthened community support structures linked to each ART site • PLHIV engaged as agents for expanding treatment coverage, including defaulter tracing	Support military PLHIV groups linked to treatment facilities	HBHC	[REDACTED]	RTI	6. Service Delivery
		Community outreach and mobilization through mentor mothers program	HBHC	[REDACTED]	SPPHC, ICAP, IHI, CMMB	
		Support structure and technical capacity of PLHIV to deliver outreach	HBHC	[REDACTED]	Linkages	
Stigma and discrimination (including self-stigma of PLHIV) resulting into low uptake of services	• Social behavior change communication to increase awareness on HIV prevention and treatment mainstreamed as part of clinical care	Integrate HIV education into routine health education at PHCCs; integrate HIV awareness into FP programs	HVAB	[REDACTED]	SPPHC	2. Policies and Governance
		Implementation of a package of PHDP services at military treatment facilities	HBHC	[REDACTED]	RTI	
		Peer outreach for FSWs and MSMs	HBHC, HVOP	[REDACTED]	Linkages	
Inadequate data systems to track retention of patients	• Establish automated reminder system for both health providers	Strengthen DHIS 2 at Juba Military Hospital for improved client tracking	HVSI	[REDACTED]	RTI	15. Performance Data

on ART	and patients.	Introduce unique identifiers for KPs	HVSI	*[REDACTED]*	Linkages	
		Training on data recording and reporting	HVSI	*[REDACTED]*	SPPHC, IHI, CMMB	15. Performance Data
TOTAL				*[REDACTED]*		

Table 6.1.3 Key Programmatic Gap #3: There is a need for a strengthened system to facilitate roll-out of quality viral load (and EID) testing, and use of the information to improve programs.

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Infrastructural modification including fixing of benches/worktops and PCR installation in the laboratory has not been completed.	• PCR lab upgrades completed, furnished, equipment installed, validated, and commissioned	Engage Global Fund and MOH to expedite procurement of required furniture and necessary materials to complete PCR room modification.	HLAB	*[REDACTED]*	AMREF	10. Laboratory
		Provide technical guidance and expertise to ensure international standards are met and equipment performs at an acceptable standard.				
Absence of specimen referral system and result transmission system to support movement of samples from facility to testing laboratory and results from testing laboratory to patient, and patient tracking systems.	• An integrated national and reliable specimen referral system is developed. • An efficient and cost effective system for relaying test results from testing laboratory to clients is established.	Develop standard operating procedures for sample storage and transportation within and outside facilities.	HTXS	*[REDACTED]*	AMREF	10. Laboratory
		Contract local transport companies to conduct sample transportation for VL monitoring				
		Procure refrigerators for storage of samples and cold chain containers for transportation of samples				
		Train health facility staff on sample collection, storage, transportation and record keeping.				
		Maintain an internet and SMS-based system for transmitting results to facilities and alerting clients.				
Inability to provide viral load monitoring to clients in distant facilities due to presence of a single PCR Roche Taqman machine approved for viral load monitoring using plasma. The same machine is also meant to be used for Early infant diagnosis.	• Availability of a high throughput PCR machine with the ability to perform quantitative RNA measurement using dried blood spot specimen. • Trained laboratory personnel with skills to perform preventive maintenance to ensure optimum performance of the PCR equipment	Provide technical guidance and expertise for equipment selection, contract development and planning of equipment placement, installation, validation and appropriate utilization.	HLAB	*[REDACTED]*	AMREF	10. Laboratory
		Procure quality control materials for the PCR machine.				
		Train laboratory personnel on equipment maintenance and repair				

Inadequate number of skilled laboratory personnel to conduct high quality PCR testing.	• Adequate number of well-trained and competent laboratory staff to conduct testing and preventive maintenance of the PCR machines.	Develop and review training materials, SOPs, job aids, registers and all required forms and for testing laboratory.	HLAB	*[REDACTED]*	AMREF	**10. Laboratory**
		Conduct competence-based training to laboratory staff.				
		Provide lab-based mentorship and lab-attachments at regional labs.				
		Train lab staff at Juba Military Hospital to operate the available PCR machine (Nucle Sens EasyQ type)	HLAB	*[REDACTED]*	RTI	
Absence of a system for collecting and managing VL data.	• Data collection and reporting tools developed and disseminated to ART sites and database established at the National Public Health Lab for managing VL data.	Develop a database for managing viral load data.	HLAB	*[REDACTED]*	AMREF	**10. Laboratory**
		Maintain network connectivity at the National Public health Laboratory.				
		Train data clerk to handle all data on samples tested and results delivered.				
Lack of in-country capacity to perform HIV early infant diagnosis (EID)	• 90% of infants age 4-6 weeks tested and HIV status known • A reliable transport system established for specimen referral • An efficient and cost-effective result transmission system developed • Facility healthcare workers trained on sample collection, storage, and transportation • Adequate number of laboratory staff trained on sample handling, testing and result reporting • Availability of all SOPs, training materials, job aids, data collection tools and policy and legislation governing EID	Expand EID testing services to all PEPFAR supported PMTCT sites	HLAB	*[REDACTED]*	AMREF	**10. Laboratory**
		Strengthen EID data management systems				
		Establish quality assurance systems for EID				
		Train all stakeholders (lab staff, PMTCT nurses, clients, data managers) on specific components of EID				
		Provide technical guidance for preparation of all EID documents				
		Enroll EID lab into external quality assurance program				
TOTAL				*[REDACTED]*		

6.2 Critical Systems Investments for Achieving Priority Policies

Based on gaps identified in the treatment and prevention cascade and data made available through the SID, Data Pack, PBAC, and other data sources, RSS PEPFAR has identified key systems barriers that are most critical to address to support the successful implementation of 1) Test and START; and 2) new and efficient service delivery models. These are described below.

Test and START

RSS PEPFAR will focus on addressing the four key systems barriers that have been identified: 1) absence to date of an official endorsement of Test and START by the MOH; 2) limited access to ART services; 3) incomplete information on the commodities and cost implications of Test and START; and 4) low ART retention rates. Although the MOH has not yet officially endorsed Test and START, the HIV technical working group, under the leadership of WHO, has begun discussions, and it is expected implementation will begin soon. The remaining systems barriers are more substantial and will require focused support in COP16. PEPFAR will work to increase access to ART services (also addressed above under Programmatic Gap 2) through the decentralization of ART services to selected high volume primary health care centers, as well as through increase mobile and community-based services for more remote areas. Through supply chain technical assistance, PEPFAR will support quantification and forecasting for Test and START so that all partners can adequately plan for the associated costs and commodities. And PEPFAR will employ a variety of mechanisms to support PLHIV on treatment in order to increase retention under Test and START.

New Service Delivery Models

RSS PEPFAR will focus on addressing the five key systems barriers that have been identified: 1) limited availability of skilled workers at all levels to facilitate community-based services and other new service delivery models; 2) inadequate treatment support for PLHIV for self-management; 3) poor integration of TB/HIV and other services; 4) limited ability of existing systems to track PLHIV as they move within the country; and 5) weak quantification and coordination of logistics between site-level pharmacies and warehouses. PEPFAR will support the optimization of existing and new health workers to support more efficient service delivery models. Community systems will also be strengthened to support PLHIV on treatment. Through supply chain TA, PEPFAR will build on previous years' support, including the development of a pharmaceutical dashboard, to improve quantification and forecasting, as well as site-level stock management, to ensure that adequate drugs are available for multi-month dispensing.

Table 6.2.1 Test and START						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP 16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
MOH has officially endorsed Test and START but is yet to operationalize it.	• Official communication from MOH on implementation of Test and START	Engage with MOH and other stakeholders to obtain official endorsement and begin operationalizing Test and START	HTXS	*[REDACTED]*	USG	2. Policies and Governance
		Support guidelines and SOPs development, printing and dissemination; Guidelines and SOP launch; Central Level TA for TB/Programmatic ART review and planning meeting / planning & support	HTXS	*[REDACTED]*	ICAP	
Access to ART clinic remains low. There are few clinics providing ART to PLHIV. Many clinics which provide HTC do not provide ART	• Decentralize ART to lower-level health facilities (e.g., current PMTCT sites) to make services accessible to populations	Decentralize ART to primary health care centers facilities to make services more accessible to populations	HTXS	*[REDACTED]*	SPPHC CMMB IHI	6. Service Delivery
		Conduct outreach services to reach low volume, remote locations	HTXS	*[REDACTED]*	SPPHC IHI, CMMB	
		Use mobile multidisciplinary teams to improve ART access in remote military garrisons	HTXS	*[REDACTED]*	RTI	
Commodities and cost implications of Test and START have not yet been analyzed	• Commodities and cost projections for Test and START developed and continuously monitored in conjunction with Global Fund	Technical assistance to support quantification and financial analysis/planning for Test and START	OHSS	*[REDACTED]*	GHSC	8. Commodity Security and Supply Chain
		Ongoing support to ensure effective utilization of the pharmaceutical dashboard				
Low ART retention rate may limit effectiveness of Test and START (i.e., PLHIV may start but then stop treatment)	• Strengthened community support structures linked to each treatment center • Employ PLHIV as agents for improving retention • Establish automated reminder system for both health providers and patients.	Community outreach and mobilization through mentor mothers and greater engagement of	HBHC	*[REDACTED]*	SPPHC, ICAP, CMMB, IHI	6. Service Delivery
		Support structure and technical capacity of PLHIV to deliver outreach	HTXS	*[REDACTED]*	Linkages	
		Facilitation of military PLHIV support groups attached to Juba Military Hospital treatment facility to improve tracking and retention	HTXS	*[REDACTED]*	RTI	
TOTAL				*[REDACTED]*		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Limited availability of skilled workers at all levels to facilitate community-based services and other new service delivery models	• Policy guidelines adopted to address number and capacity of human resources for health (HRH) to initiate new patients and manage patients who are unstable and/or at risk of treatment failure	Train 30 mobile multidisciplinary teams to address HRH challenges	HTXS	*[REDACTED]*	RTI	6. Service Delivery 7. Human Resources for Health
		Hiring and training of new staff at facilities	HTXS	*[REDACTED]*	SPPHC, RTI, ICAP, CMMB, IHI	
PLHIV within communities receive inadequate treatment support for self-management	• Policy adopted to support PLHIV groups (and other community systems strengthening approaches to promote testing and treatment) • Strong model of community support systems implemented for priority groups/SNUs (e.g., KPs)	Community outreach and mobilization through mentor mothers program	HBHC	*[REDACTED]*	SPPHC, IHI, ICAP, CMMB	6. Service Delivery
		Peer groups for FSWs implemented to increase peer support and improve adherence	HTXS	*[REDACTED]*	Linkages	
		Facilitate PLHIV support group linked to Juba Military Hospital to track and offer adherence support	HTXS	*[REDACTED]*	RTI	
TB/HIV and other services are poorly integrated	• Improved integration of services, as evidenced by cross-training, improved PITC, etc • Increased proportion of HIV positive individuals screened for TB	Support SPLA TB facility to improve service delivery through capacity building, supportive supervision, and mentoring	HVTB	*[REDACTED]*	RTI	
		Routine screening of HIV positive individuals for TB	HVTB	*[REDACTED]*	ICAP, CMMB, IHI, SPPHC	
Limited ability of existing systems to track PLHIV as they move within the country (highly mobile population)	• Unique identifier system developed and piloted for key populations	Introduce unique identifiers for KPs	HVSI	*[REDACTED]*	Linkages	
Weak quantification and coordination of logistics between site-level pharmacies and warehouses, limiting the ability to move to multi-month dispensing	• MOH-led quantification completed every six months • Establishment of an informed push system at sites and improved capacity of facility staff to prevent stock outs • Three-month dispensing implemented	Support for quantification and ongoing monitoring of stock at all levels	OHSS	*[REDACTED]*	GHSC	8. Commodity Security and Supply Chain
		Coordinate with stakeholders to develop an implementation plan for operationalizing multi-month dispensing				
TOTAL				*[REDACTED]*		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

The following table includes all other system investments proposed for COP16, which are not included in either 6.1 or 6.2. It describes how each activity is essential in reaching the 90/90/90 targets and achieving a sustainable national HIV program.

Table 6.3 Other Proposed Systems Investments							
Systems Category*	Activity	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
Governance							
Guidelines, Policy	• Improve capacity to implement a national HIV rapid test kit quality assurance program • Provide appropriate guidance for HIV test kit selection and designing a testing algorithm aligned with the country's algorithm • Develop and disseminate QA SOPs and guidelines to all sites • Train laboratory staff on proficiency panel preparation • Train testers on testing and reporting of proficiency panel results • Coordinate distribution of panels to testing sites • Provide technical assistance for corrective action implementation and quality improvement • Develop a data management system for HIV rapid test proficiency testing	First 90	• Accurate and reliable HIV test results (reduced false test results) • Functional proficiency testing program for HIV rapid test • A nationally approved HIV testing algorithm	*[REDACTED]*	HLAB	AMREF	
HRH - Systems/Institutional Investments							
Inst & Org Development							

Laboratory							
Quality management systems	• Implement a national quality improvement program that supports HIV care and treatment • Provide continuous professional in-service training to laboratory staff • Develop laboratory information management system • Enroll clinical laboratories into proficiency testing programs for diagnosing opportunistic infections (TB, bacteriology, parasitology)	First 90	• Increased number of laboratories with capacity to perform clinical tests. • Improved safety of laboratory staff, clients, patient samples and environment. • Provision of timely and reliable laboratory results in an efficient and effective manner • Improved documentation of laboratory data for clinical decision making • Increase the number of laboratories participating in proficiency testing programs	*[REDACTED]*	HLAB	AMREF	9. Quality Management
Implementation of diagnostics	• Ensure availability of CD4 testing to patients without access to viral load services, as viral load testing is introduced and scaled up • Monitor performance of CD4 analyzers and provide preventive and repair services • Enroll CD4 testing laboratories into a proficiency testing program	Third 90	• Availability of quality CD4 testing until all patients are able to access VL monitoring • Improved access to VL monitoring to increased number of ART clients and reduction of CD4 test for patient monitoring	*[REDACTED]*	HLAB	AMREF	10. Laboratory
Strategic Information							
Monitoring and evaluation, capacity building	• Support an embedded M&E Technical Advisor in the Ministry of Health	First, second, and third 90s	• Streamlined reporting for HIV (all partners reporting through national M&E framework) • All HIV data is routinely reported through the national HMIS • Increased capacity of Global Fund, MOH, and PEPFAR project staff to accurately report and analyze HIV data	*[REDACTED]*	HVSI	SPPHC	15. Performance Data
Systems Development							
Supply chain	• Technical assistance to the Central Medical Stores and Logistics Management Unit • Strengthen logistics and management of storage and delivery of HIV commodities • Development of tools and guidance for supply chain management • Support use of data to effectively manage supply chain	First, second, and third 90s	• Improved capacity of Central Medical Stores and Logistics Management Unit to support all supply chain functions (e.g., quantification, warehousing, distribution, monitoring, quality assurance) • Adequate commodities available at national level and reduction of stock-outs at facility level to support the HIV program	*[REDACTED]*	OHSS	GHSC	8. Commodity Security and Supply Chain

	• Support strategic planning for commodity supply in relationship to new treatment guidelines, testing algorithms, etc						
Blood safety	• Provide technical assistance to improve testing of blood units for Transfusion Transmissible Infections TTI • Promote appropriate use of blood and blood products • Establish data management procedures for blood and blood products	First 90	• Improved quality of laboratory testing procedures in the blood center • Established standards for safe collection, storage, testing and transfusion of blood • Reduced number of TTI through blood transfusion • Proper documentation blood bank data	*[REDACTED]*	HMBL	AMREF	
TOTAL				*[REDACTED]*			

7.0 Staffing Plan

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16			
Level of Implementation	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Site level	**HTC:** • HTC in facility, community, and PMTCT sites with a focus on key and other vulnerable populations, high-prevalence populations, and scale-up SNUs • Strategies to focus HTC at high yield population and testing near with view of treatment. • Expansion of HTC, especially PITC and index case testing, at existing treatment sites • Prioritized pediatric HIV testing • Procurement of limited HTC commodities (RTKs) **Care and Treatment:** • DSD to ART and PMTCT sites in three focus states to Test and START all PLHIV on treatment • Targeted capacitation of ART service delivery at high-yield PMTCT/HTC sites to improve access to ART services for pregnant and breastfeeding mothers, their partners, and children **Prevention:** • Support for linkages/referrals to facility-based comprehensive HIV care and treatment services (including adherence support) • Option B+ implementation at all PEPFAR sites • STI screening, prevention, and treatment **OVC** • HTC and linkage to care and treatment for OVC • Psychosocial support • Economic strengthening • Educational and nutritional support **TB/HIV:** • **DSD** to ART sites in three focus states in TB/HIV integration **Laboratory:** • Direct service delivery, including CD4 testing, viral load testing, and EID **Strategic Information** • Quarterly supportive supervision and data quality assurance at service delivery sites	**Care and Treatment:** • Targeted TA to ART sites in seven non-focus states TA including standardized, routine mentorship and supportive site supervision **TB/HIV:** • Targeted TA to ART sites in seven non-focus states TA including standardized, routine mentorship and supportive site supervision in TB/HIV integration	
Level of Implementation	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Sub-national level	**HTC:** • HRH for HTC, including training **Care and Treatment:** • Prioritized pediatric HIV care and treatment • Targeted care and treatment for key populations **Prevention:** • Scale-up of targeted, high-impact prevention interventions (behavioral, structural, biomedical) for key and other high-risk/vulnerable populations • Condom and lubricant promotion and distribution • PMTCT Option B+ roll out **OVC** • Training and mentorship to health care workers and social welfare support providers • Linkage to care and treatment to the existing treatment centers at the sub national units • Case management for beneficiaries from PLHIV families	**Prevention:** • Targeted SBCC at health facility • Risk reduction counseling and skills training • Community mobilization and empowerment through engagement of county and state leadership **Laboratory**: • Support for lab-related HRH, including pre- and in-service training and mentorship • Infrastructure support, including standardization, management, and maintenance of lab equipment **Strategic Information:** • Capacity building for strategic information, including training and	

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	Laboratory: • Support for supply chain management, including standardizing required supplies/reagents and developing tools for quantification and distribution **Strategic Information:** • Quarterly monitoring and data quality assurance of facility-based programs	mentoring of MOH staff	

National level	**HTC:**
	• Support for HTC systems, including development of standardized HTC tools, SOPs for linkage/referral
	Care and Treatment:
	• TA and DSD support for rollout of revised WHO care and treatment guidelines for test and treat nationwide (facility preparation, HRH, M&E)
	OVC
	• TA and support to roll out OVC program in Juba County through the coordination with the county health department and department of social welfare.
	• Community mobilization to support OVCs as well as protecting children.
	• Advocacy with stakeholders
	Prevention:
	• TA and support for rollout of Option B+ nationwide (facility preparation, HRH, M&E)
	• TA and support for a national key population program rollout.
	• Expansion of prevention interventions targeting MSM
	Laboratory:
	• Support for establishment of a comprehensive quality management system (QMS), including implementing QA labs and systems
	Strategic Information:
	• Surveillance and programmatic data collection, including:
	   o Bio-behavioral surveys of key and other vulnerable populations
	   o AIS indicator survey
	   o Support to the MOH to conduct national ANC surveillance
	   o PMTCT data quality assessment
	   o Implementation of a data tool among IPs to collect real-time bio-behavioral data from patients accessing HTC services
	   o Support for MOH development of HIV estimates and projections with UNAIDS
	• Support national surveillance, health information, and data management systems
	Health Systems Strengthening:
	• TA to strengthen of the national M&E system
	• Strengthening of M&E and supportive supervision throughout the health system
	• Support the procurement of additional ARVs and RTK to cover national commodity gaps for Test and START.
	• TA to the supply chain system, especially coordination, quantification and distribution of HIV commodities
		Prevention:
		• Capacity building of civil society organizations to create awareness and increase service uptake among key and other vulnerable populations
		Laboratory:
		• TA to MOH for org/management structure
		• Support to laboratory accreditation and implementing lab standards and guidelines
		• Support for Laboratory Information Management Systems (LIMS), including establishment of a paper-based LIMS and a feasibility assessment for an electronic LIMS
		• Support for lab M&E, including development of lab indicators and tools	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16			
HTC	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• HTC in facility, community, and PMTCT sites with a focus on key and other vulnerable populations, high-prevalence populations, and scale-up SNUs • Expansion of HTC, especially PITC and index case testing, at existing treatment sites • Prioritized pediatric HIV testing • Procurement of limited HTC commodities (RTKs) • HRH for HTC, including training • Support for HTC systems, including update and development of standardized HTC guidance, tools, and SOPs for linkage/referral	•	
Care and Treatment	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• TA to ART sites in three focus states • TA and DSD to all prioritized PHCC to initiate all PLHIV on treatment • Targeted capacitation of ART service delivery at high-yield PMTCT/HTC sites to improve access to ART services for pregnant and breastfeeding mothers, their partners, and children • Prioritized pediatric HIV care and treatment • Targeted care and treatment for key populations		
Prevention	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• TA and support for rollout of Option B+ nationwide (facility preparation, HRH, M&E) • Scale-up of targeted, high-impact prevention interventions (behavioral, structural, biomedical) for key and other high-risk/vulnerable populations • Condom and lubricant promotion and distribution • STI screening, prevention, and treatment • Support structure and technical capacity of PLHIV to deliver outreach • Start-up safe and secure drop in center for FSW and MSM • Support for linkages/referrals to facility-based comprehensive HIV care and treatment services (including adherence support)	• Targeted BCC • Risk reduction counseling and skills training • Community mobilization and empowerment • Capacity building of civil society organizations to create awareness and increase service uptake among key and other vulnerable populations • Continued exploration of prevention interventions targeting MSM	
TB/HIV	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• TA to ART sites in three focus states in TB/HIV integration • TA to county and state leadership for collaborative TBHIV mentorship and support supervision activities at health facilities		
Cross-cutting	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Laboratory	• Direct service delivery, including CD4 testing, viral load testing, and EID • Support for establishment of a comprehensive quality management system (QMS), including implementing QA labs and systems, expanding SLMTA, and implementing lab	• TA to MOH for org/management structure • Support for lab-related HRH, including pre- and in-service training and mentorship • Support for Laboratory Information Management Systems (LIMS), including	

		establishment of a paper-based LIMS and a feasibility assessment for an electronic LIMS • Support for lab M&E, including development of lab indicators and tools • Infrastructure support, including standardization, management, and maintenance of lab equipment • Support to laboratory accreditation and implementing lab standards and guidelines	
Strategic Information	**Core Activities**	**Near-core Activities**	**Non-core Activities**

	• Surveillance and programmatic data collection, including:
	   o Bio-behavioral surveys of key and other vulnerable populations
	   o HIA in three high-prevalence focus states
	   o Support to the MOH to conduct national ANC surveillance
	   o PMTCT data quality assessment
	   o Implementation of a data tool among IPs to collect real-time bio-behavioral data from patients accessing HTC services
	   o Support for MOH development of HIV estimates and projections with UNAIDS.
	• Quarterly supportive supervision and data quality assurance at service delivery sites
	• Support national surveillance, health information, and data management systems
		• Capacity building for strategic information, including training and mentoring of MOH staff	

Health System Strengthening	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	• TA to the supply chain system, especially coordination and distribution of HIV commodities • Procurement of ARV and RTKs	• TA to strengthen of the national M&E system • Strengthening of M&E and supportive supervision throughout the health system	

Table A.3 Transition Plans for Non-core Activities						
Transitioning Activities	Type of Transition	Funding in COP 16	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
None						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$534,002	$20,994,302	$21,528,304

Table B.1.2 Resource Allocation by PEPFAR Budget Code (New Funding Only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated[14]
CIRC	Male Circumcision	$ -
HBHC	Adult Care and Support	$ 607,618
HKID	Orphans and Vulnerable Children	$ 669,694
HLAB	Lab	$ 929,195
HMBL	Blood Safety	$ 183,629
HMIN	Injection Safety	$ -
HTXS	Adult Treatment	$ 7,560,183
HTXD	ARV Drugs	$ 1,829,817
HVAB	Abstinence/Be Faithful Prevention	$ -
HVCT	Counseling and Testing	$ 3,687,359
HVMS	Management & Operations	$ 1,796,132
HVOP	Other Sexual Prevention	$ 851,731
HVSI	Strategic Information	$ 955,663
HVTB	TB/HIV Care	$ 405,342
IDUP	Injecting and Non-Injecting Drug Use	$ -
MTCT	Mother to Child Transmission	$ 661,583
OHSS	Health Systems Strengthening	$ 643,863
PDCS	Pediatric Care and Support	$ -
PDTX	Pediatric Treatment	$ 212,493
TOTAL		**$20,994,302**

B.2 Resource Projections

Resource projections were made based on epidemiological, programmatic, and expenditures data in the 19 Aggressive Scale-up, Sustained, and Centrally Supported SNUs. Targets were set using a single national and agreed unit expenditure (UE) for all agencies. No differentiation was made between UEs for Aggressive Scale-Up SNUs and Sustained SNUs because the package of services will be the same in all supported facilities.

---

[14] Includes applied pipeline

Expenditures analysis (EA) data and the UEs in the data navigation tool formed the starting point for the target-based budgeting approach. The team jointly reviewed the UEs that were reported for the FY2015 EA, reviewed each cost category, and made adjustments based on the package of services planned for COP16. Some fixed costs were held constant, while other cost categories that are directly related to the number of beneficiaries were left to multiply by the COP16 targets. Other costs were increased to reflect the rising operational costs in South Sudan. Those adjusted costs were divided by nominal targets set for each respective program area in COP16, which then resulted in the applied UEs that were entered into PBAC and used for PEPFAR South Sudan's target-based budgeting approach.

The following describes the cost category adjustments made to each of South Sudan's COP16 applied UEs:

- **Adult ART (DSD)** - Outliers (Linkages and ICAP - Northern Bahr el Ghazal, an SNU that will no longer be funded for activities) were removed. The cost of ARVs was removed from the unit expenditure in order to be budgeted separately as a lump sum. In-service training costs were doubled to account for training needed for Test and START and new service delivery models. Vehicle costs were removed. Equipment and furniture costs were held constant (with some extra costs included as lump sums). Personnel costs were increased by $567,600 based on the addition of 109 staff. Building rental and utilities, and strategic information costs were held constant. Travel was increased by 20% and then held constant to account for increased supervision and rising fuel costs. Program management costs were increased by 10% to reflect rising RSS operational costs and the increased focus on treatment.
- **Adult ART (TA)** – The TA UE was calculated based on FY2015 EA data for the same implementing partner. A weighted average for the three SNUs where TA will be provided in COP16 was calculated. This figure was then adjusted by doubling in-service training, increasing travel by 20%, and increasing program management by 10% to account for rising fuel and program management costs.
- **Pediatric ART** - The same cost is anticipated for Pediatric ART as for Adult ART.
- **Pregnant women tested and receiving results** – In-service training, program management, and strategic information costs were held constant. Personnel was increased by 5% to account for rising salaries and then held constant. Travel was increased by 20% and then held constant to account for increased supervision and rising fuel costs.
- **Women receiving ARV prophylaxis** – The cost of ARVs was removed from the unit expenditure in order to be budgeted separately as a lump sum. In-service training costs were removed because they will be covered under Adult ART. Personnel, building rental and utilities, program management, and strategic information costs were held constant. Travel and transport was increased by 10% and then held constant to account for increasing fuel prices.
- **VCT clients** – The 2015 EA average UE for HTC was applied for COP16. Due to some reporting inconsistencies, this same figure will be used as the applied UE for COP16 for both VCT and PITC.

- **PITC clients** – The 2015 EA average UE for HTC was applied for COP16. Due to some reporting inconsistencies, this same figure will be used as the applied UE for COP16 for both VCT and PITC.
- **CBTC clients** - The cost of HIV test kits was removed from the unit expenditure to be budgeted separately as a lump sum. Travel and transport and program management costs were each increased by 10% to account for rising operational costs (including fuel). In-service training costs were doubled to account for increases in planned training.
- **OVC** - As OVC programming is new in South Sudan, the applied UE was calculated based on the planned budget and expected number of beneficiaries.
- **Female sex workers reached** - The 2015 EA UE was applied for COP16. While the 2015 KP-FSW UE reflects one new mechanism that reported a relatively small number of expenditures and beneficiaries during its first few months of startup, it is expected that the investment expenditures will shift downward and recurrent expenditures will increase during FY16.
- **MSM reached** - The KP-FSW UE was applied for KP-MSMTG as the best estimate of costs. FSWs and MSMs will both be targeted under the same program, with similar packages of services.

For the activities reported in the lump sum budgeting tab in PBAC, the following approaches were used:

- Commodities costs were calculated using the commodities calculator tool based on COP16 targets, and also taking into account planned procurements by the Global Fund. Freight costs were calculated as 30% of total commodity costs. Technical assistance costs were calculated based on the expected scope of activities in COP16 (expanded work on quantification to support Test and START, and multi-month scripting ("MMS" or "MMP"), continued work on central level systems strengthening, and support for distribution of commodities to site level).
- Containers were budgeted at $15,000 each. These will be used as modular spaces at health facilities that are expanding to provide ART services, providing the needed extra space for seeing patients in a confidential manner, and for storing drugs.
- Costs were budgeted, based on historic costs, to support decentralized systems strengthening and support capacity building in M&E, in support of the identified programmatic gaps to achieve 90-90-90.
- Laboratory and strategic information support were budgeted based on historic costs.
- Start-up and operational costs for three drop-in centers were budgeted for the Linkages project. Additional funds were also budgeted for advocacy work related to service provision for key populations, as well as to support the development of a unique identifier system for key populations.
- Site-level PLHIV engagement was budgeted at $15,000 per site (or $30,000 for larger sites). This is based on the estimated costs of sub-contracting to local PLHIV associations to support HIV testing, treatment, and adherence in 15 sites.
- State-level support for the three Equatoria states was budgeted at $31,899 per state.

- Central-level technical assistance to the Ministry of Health to support treatment activities was budgeted based on historic costs.

APPENDIX C

Systems Investments for Section 6.0

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included